

17575

CERTIFICATE OF DEATH

17567

| | | | |
|---|---|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 8 Days | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | d. STREET ADDRESS 3906 92 Ave | |
| 3. NAME OF DECEASED (Type or print) LOVELL EARNEST ANDREWS | | 4. DATE OF DEATH 28 DECEMBER 19 66 | |
| 5. SEX MALE | 6. COLOR OR RACE CAU | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9 DEC 1904 |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN | | 10b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR | |
| 11. BIRTHPLACE (County & State, or foreign country) PAGE COUNTY, VA | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME IRA JACOB ANDREWS | | 14. MOTHER'S MAIDEN NAME ANNIE MARY SAMUELS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO | | 16. SOCIAL SECURITY NO. NO | |
| 17. INFORMANT SON-CLARENCE * SAME AS # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY AND CARDIAC ARREST DUE TO (b) ACUTE PULMONARY EDEMA DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIFFUSE ENCEPHALOPATHY OF UNDETERMINED ETIOLOGY | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 21 (this hospital) attended the deceased from 20 DEC , 19 66 , to 28 DEC , 19 66 , that (I) 21 saw the deceased alive on 28 DEC , 19 66 , and that death occurred at 4:10 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Ira A. Gould | | 22b. DATE SIGNED 28 DEC | |
| 22c. PHYSICIAN'S NAME (Type) IRA A. GOULD, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS WASH, D.C. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-31-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY DELLINGER GRAVEYARD | | 23d. LOCATION (City or Town) (County) (State) SPRASBURG VA | |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM | | 25a. REC'D BY REGISTRAR 4308 SUTLAND RD | |
| 25b. REGISTRAR'S SIGNATURE 3 1967 | | 25c. REGISTRAR'S SIGNATURE Robert E. Wilhelm | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1983

UNITED STATES

2010

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 17576 CERTIFICATE OF DEATH 17568 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY in 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE VIRGINIA b. COUNTY ALEXANDRIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALEXANDRIA d. STREET ADDRESS 4811 POPULAR DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First JULIE Middle ANN Last ATKINSON | | | | 4. DATE OF DEATH Month DECEMBER Day 3 Year 19 66 | | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1 DECEMBER 1966 | | 9. AGE (In years last birthday) yrs. 3 IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | | | 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S, MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME EUGENE FRANKLIN ATKINSON | | | | | | 14. MOTHER'S MAIDEN NAME JULIE ANN ATKINSON <i>Shirley Joan Jordan</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) N/A | | | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT FATHER SAME AS # 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 760.5 DUE TO Premature Lungs & Interventricular Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1 DEC 1966 to 3 DEC 1966 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 3 DEC 1966 and that death occurred at 11:30 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>Paul H. Perlstein</i> M.D. | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) PAUL H. PERLSTEIN, CAPT, USAF, MC | | | | | | 22d. ADDRESS USAF HOSPITAL ANDREWS, WASH, D.C. 20331 ANDREWS AFB | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 23b. DATE THEREOF 9 DEC 66 | | 23c. NAME OF CEMETERY OR CREMATORY D.C. MORGUE | | 23d. LOCATION (City, town or county) (State) WASHINGTON, D.C. | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Carl T. Curren</i> | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DEC 7 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

6-232755

17356

Journal of James E. McPherson

1862

— *My first letter* —

My dear mother

I received your letter of the 10th

and was glad to hear from you

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|---------------------------|---|---|---|-----------------------------------|--------------------------------------|---|--|--|--|
| 17577 CERTIFICATE OF DEATH 17569 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT 16.1 | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGE GENERAL | | | | | d. STREET ADDRESS 6829 ROOSEVELT AVENUE | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JOHN Middle G. Last AUGUSTINE | | | 4. DATE OF DEATH Month DECEMBER Day 11 Year 19 66 | | | | | | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JUNE 16, 1886 | | 9. AGE (In years last birthday) 80 yrs. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) barber | | | 10b. KIND OF BUSINESS OR INDUSTRY service | | 11. BIRTHPLACE (County & State, or foreign country) HUNGRY | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |
| 13. FATHER'S NAME ? AUGUSTINE | | | | | 14. MOTHER'S MAIDEN NAME UNKNOWN | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address JULIA AUGUSTINE 6829 ROOSEVELT AVENUE | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 52 hrs | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2/8/1954 to 12/11/1966, that (I) (we) last saw the deceased alive on 12/10/1966, and that death occurred at 9:15 P.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <i>[Signature]</i> | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS F.E. Mosser, M.D. 4410 24th Ave Hyattsville | | | 22b. DATE SIGNED 12/11/66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE THEREOF DEC. 13, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | | 23d. LOCATION (City, town or county) (State) PRINCE GEORGES, MARYLAND | | | |
| 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUTLAND ROAD, SUTLAND MARYLAND | | | | | 25a. REC'D BY REGISTRAR DATE DEC 15 1966 | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

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FOR STATE
HEALTH DEPT

17578

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17570

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside d. STREET ADDRESS 4945 Marlboro Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Jackie Sue Balderson | | 4. DATE OF DEATH Month 12 Day 24 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 26 July 1947 |
| 9. AGE (In years last birthday) yrs. 19 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper | |
| 11. BIRTHPLACE (State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Herman Balderson | | 14. MOTHER'S MAIDEN NAME Anna E. Blaine | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Anna E. Blaine | | Address 1527 62nd Pl. Spaulding Hgts | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 976X IMMEDIATE CAUSE (a) Gun shot wound of chest DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest with a .22 cal. revolver | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12-23- 19 66 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home |
| 20f. (City or town) same as #2 | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe | | 22. DATE SIGNED 12-26-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/28/66 | 23c. NAME OF CEMETERY OR CREMATORY Epiphany Church Cemetery | 23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland |
| 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME | | 25. REC'D. BY REGISTRAR DET 29 1966 | |
| 4308 SUITLAND ROAD, SUITLAND MARYLAND | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17579

CERTIFICATE OF DEATH

17571

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb. 27 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park | | 16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 9405 Rhode Island Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Raphael S Barton | | 4. DATE OF DEATH Dec. 4 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 - 14 - 1903 |
| 9. AGE (In years last birthday) 62 yrs. | | 10. IF UNDER 1 YEAR: Months 4 Days 19 Hours 66 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardmaster | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Charles L Barton | | 14. MOTHER'S MAIDEN NAME Myrtle M Slayman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 718 14 9734 | |
| 17. INFORMANT Katheryn A Barton | | Address College Park, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized Peritonitis DUE TO Blowout of gastroduodenostomy Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. severe coronary atherosclerotic Heart Disease DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11-7 , 19 66 , to 12-4 , 19 66 ; that (I) (we) last saw the deceased alive on 12-3 , 19 66 , and that death occurred at 3:25 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE William B. Hagan M.D. | | 22b. DATE SIGNED 12-4-66 | |
| 22c. PHYSICIAN'S NAME (Type) William B Hagan | | 22d. ADDRESS Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 7, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DEC 6 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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RECEIVED ON FILE

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17580

CERTIFICATE OF DEATH

17572

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| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| c. LENGTH OF STAY IN b. 11 hrs. 15 min. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 6221 64th Ave. | |
| 3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last Becker | | 4. DATE OF DEATH Month Dec. Day 7 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5 Dec., 1966 |
| 9. AGE (In years last birthday) 1 | | 10. F UNDER 1 YEAR Months 1 Days 11 Hours 15 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Pr. Geo. Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert James Becker | | 14. MOTHER'S MAIDEN NAME Sandra Louise Burgess | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mother | | Address Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral Abductus 7625 DUE TO (b) Prematurity (1200 gms) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 5, 1966 to Dec. 7, 1966 , that (I) (we) last saw the deceased alive on Dec. 7, 1966 , and that death occurred at 5:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Bertha E. Van Gelderen</i> | | 22b. DATE SIGNED 12/7/66 | |
| 22c. PHYSICIAN'S NAME (Type) Bertha E. Van Gelderen, M.D. | | 22d. ADDRESS =3001 Cheverly Ave., Cheverly, Md. | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Cremation | 23b. DATE THEREOF 12/17/66 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 21 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17581

Items 3, 14, 18 Film 3584 1/6/67 mh

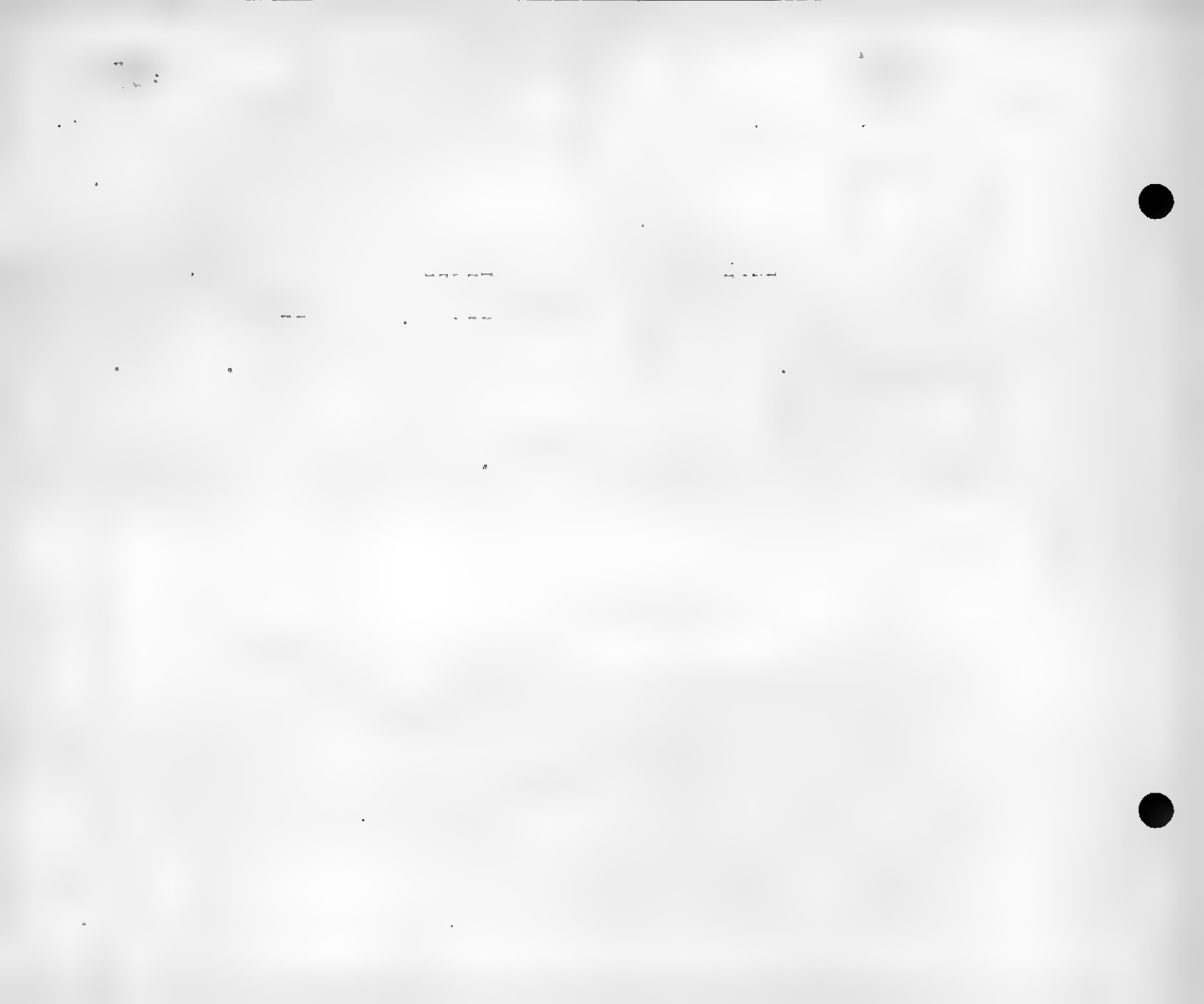
CERTIFICATE OF DEATH

17573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 15 hrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 3407 Taylor Street | |
| 3 NAME OF DECEASED (Type or print) Milton | | 4 DATE OF DEATH Month Dec. , Day 12 , Year 1966 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years last birthday) 10 Oct., 1901 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consulting Att. | | 11 BIRTHPLACE (County & State, or foreign country) Pittsburgh, Penna. | |
| 13 FATHER'S NAME Frank Buschek | | 14 MOTHER'S MAIDEN NAME Lillian Y Slaby | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 217-44-2427 | |
| 17. INFORMANT Mrs. Frances N. Bell (above address) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary emboli (Rt lung) & edema DUE TO (b) Coronary thrombosis (Rt coronary) DUE TO (c) Generalized carcinomatosis (lymphosarcoma) | | INTERVA. BETWEEN ONSET AND DEATH 3 days 1 day Several weeks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MED. CAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from 12/14/66 to 12/12, 1966 , that (I) (we) last saw the deceased alive on 12/12, 1966 , and that death occurred at 6:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/14/66 | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR Malley's Funeral Home Inc. | | 25a. REC'D BY REGISTRAR Maryland | 25b. REGISTRAR'S SIGNATURE [Signature] |



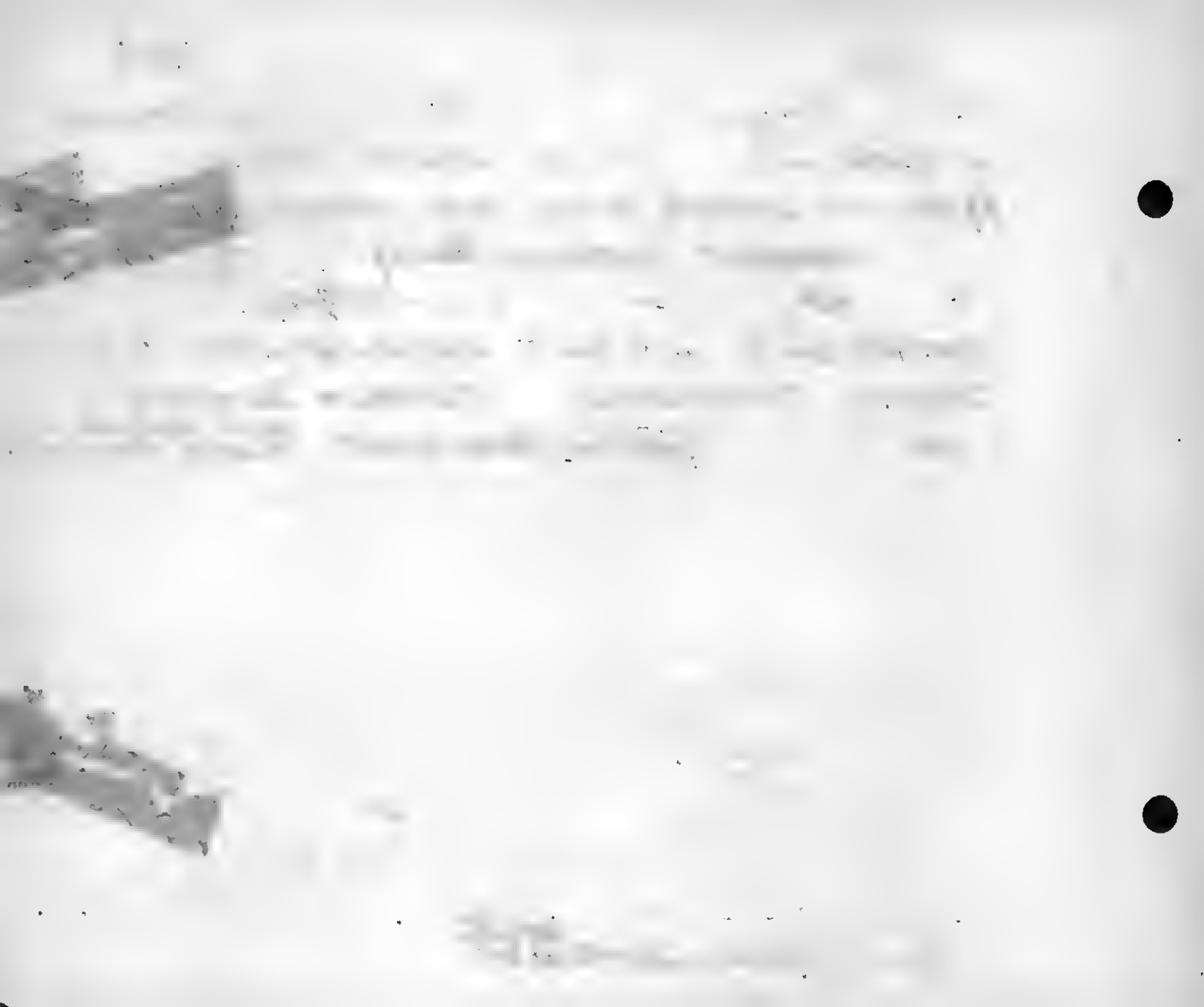
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VR A15 (4)
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
|--|--|-----------------------------|--|--|--|--|--|---|--|--|--|---|--|--|--|
| 17582 | | | | | | CERTIFICATE OF DEATH | | | | | | 17574 | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u> | | | | | | c. LENGTH OF STAY IN 1b <u>28 mos.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HYATTSVILLE NURSING HOME</u> | | | | | | | | | | | | d. STREET ADDRESS <u>10317 NAGLEE RD.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MARGARET CORDELIA BERRY</u> | | | | | | 4. DATE OF DEATH <u>12 17 1966</u> | | | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>WH.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-11-1873</u> | | 9. AGE (In Years, la rthday) <u>93</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GOV'T.</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T</u> | | 11. BIRTHPLACE (County, State, in country) <u>WASHINGTON, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | |
| 13. FATHER'S NAME <u>DANIEL SPAULDING</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>CECELIA DOWNEY</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>579-127354A</u> | | 17. INFORMANT <u>HELEN HUGHES</u> | | Address <u>10317 NAGLEE RD. SILVER SPRING MD.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF RIGHT OVARY</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____ | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>3 MO.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1</u> , 19 <u>66</u> , to <u>Dec 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 15</u> , 19 <u>66</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Thomas F. Collins</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-17-66</u> | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. COLLINS</u> | | | | | | 22d. ADDRESS <u>322 H ST NE</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | | 23b. DATE THEREOF <u>12-20-66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEM.</u> | | 23d. LOCATION (City, town or county) (State) <u>WASHINGTON D. C.</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>Francis J. Collins</u> | | | | | | ADDRESS <u>3824 14th St NW</u> | | 25a. REC'D BY REGISTRAR <u>DEC 22 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | |

MEDICAL CERTIFICATION



TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17583 CERTIFICATE OF DEATH 17575

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince Geo.</i> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Cheverly</i> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Columbia Pk</i> | |
| c. LENGTH OF STAY IN ID <i>D.O.A.</i> | | d. STREET ADDRESS <i>1610 Columbia Ave</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Prince George's General Hospital</i> | | | |
| 3. NAME OF DECEASED (Type or print) First <i>FRANK</i> Middle <i>L.</i> Last <i>BOGAN</i> | | 4. DATE OF DEATH Month <i>12</i> - Day <i>23</i> Year <i>1966</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 20, 1909</i> |
| 9. AGE (In years last birthday) <i>57</i> yrs. | | 10. IF UNDER 2 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>automobile</i> | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Pa</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i> | |
| 13. FATHER'S NAME <i>Warwick C Bogan</i> | | 14. MOTHER'S MAIDEN NAME <i>Matthi F. Skelton</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>230 16 16 94</i> | |
| 17. INFORMANT <i>Margaret M Bogan</i> | | Address <i>Columbia Park Rd</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis, Acute</i> DUE TO (b) <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i>Diabetes Mellitus</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>10/21/1966</i> to <i>12/23/1966</i> , that (I) (we) last saw the deceased alive on <i>12/26/1966</i> , and that death occurred at <i>7:37 AM</i> from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>William D. Rosson, M.D.</i> | | 22b. DATE SIGNED <i>12/23/66</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>William D. Rosson, M.D.</i> | | 22d. ADDRESS <i>5701 85th Ave., Hyattsville, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 23b. DATE THEREOF <i>Dec 27, 1966</i> | 23c. NAME OF CEMETERY OR CREMATORY <i>Cleek Cemetery</i> | 23d. LOCATION (City, town or county) (State) <i>Hot Springs, Virginia</i> |
| 24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i> | | 25a. REC'D BY REGISTRAR <i>DEC 27 1966</i> | |
| ADDRESS <i>Hyattsville, Md.</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17584

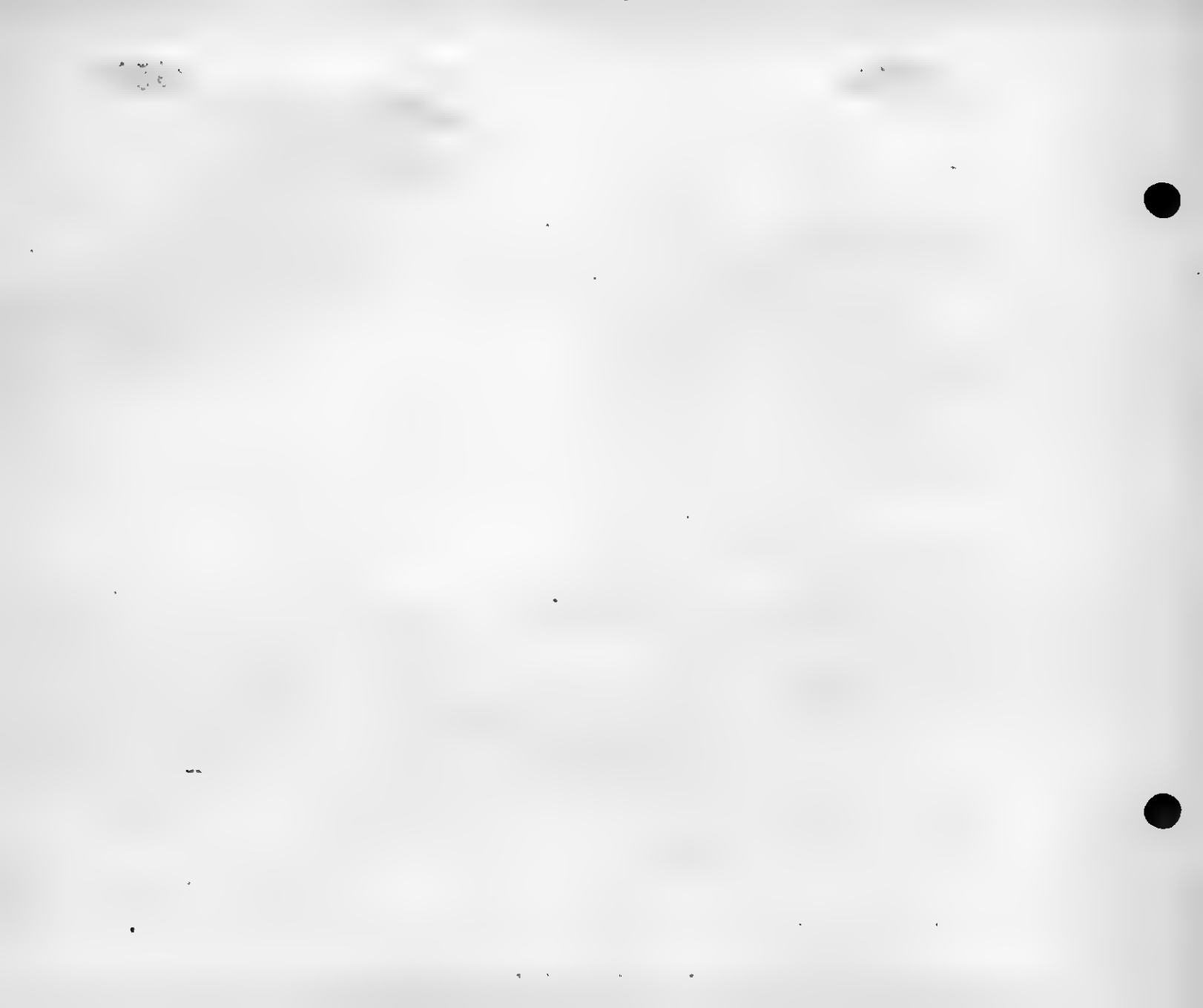
CERTIFICATE OF DEATH

17576

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN lb 25 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 332 Channing St., N. E. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital, Glenn Dale, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Essie A. Bonner | | 4 DATE OF DEATH Month Day Year 12 30 19 66 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 11/23/1890 |
| 9. AGE (In years last birthday) 76 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 11. BIRTHPLACE (County & State, or foreign country) Tennessee | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Joseph | | 14. MOTHER'S MAIDEN NAME Sarah Malinda | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 577-30-9457 | |
| 17. INFORMANT Decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Generalized arteriosclerosis and arteriosclerotic heart disease.</u> (c) <u>unknown</u> | | | INTERVAL BETWEEN ONSET AND DEATH 3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 12/5/1966 to 12/30/1966, that (X) (we) last saw the deceased alive on 12/30/1966, and that death occurred at 1:05 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/30/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1-3-1967 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery | 23d. LOCATION (City or Town) (County) (State) Arlington, Va. |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300 4th, St. N.E. D.C. | | 25a. REC'D BY REGISTRAR DATE JAN 5 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17585

CERTIFICATE OF DEATH

17577

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PG County. | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland. | | b. COUNTY Prince Georges. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN TB 16 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | 161 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital. | | | | d. STREET ADDRESS 5610 Randolph St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Edna May Boteler. | | | | 4. DATE OF DEATH 12 20 1966 | | Month Day Year | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-23-08 | |
| 9. AGE (In years last birthday) 28 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | | 11. BIRTHPLACE (County & State, or foreign country) Marly, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk. | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Marly, Maryland | |
| 13. FATHER'S NAME Edward De Witt Boteler. | | | | 14. MOTHER'S MAIDEN NAME Hattie I. Walker. | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 577 03 8427 | | 17. INFORMANT Hospital Records. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO <u>RENAL CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>100X</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-4, 1966, to 12-20, 1966, that (I) (we) last saw the deceased alive on 12-20, 1966, and that death occurred at 7:20 P.M., from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE C. J. Houmann | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-20-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) C. J. HOUMANN | | 22d. ADDRESS RIVERDALE MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 23, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons - Hyattsville, Md | | ADDRESS | | 25a. REC'D BY REGISTRAR DEC 27 1966 | | 25b. REGISTRAR'S SIGNATURE | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17586

CERTIFICATE OF DEATH

17578

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 6 HR 54 MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND d. STREET ADDRESS 4662 HOMER AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) LISA MICHELLE BOUSMAN | | 4 DATE OF DEATH Month DECEMBER Day 31 Year 19 66 | |
| 5 SEX FEMALE | 6 COLOR OR RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 DEC 1966 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S MARYLAND |
| 13. FATHER'S NAME DAVID PRESTON BOUSMAN | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A | | 14. MOTHER'S MAIDEN NAME KAREN LEE BALLANCE | |
| 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT DAVID P BOUSMAN-FATHER-SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 7735 IMMEDIATE CAUSE (a) PREMATUREITY DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RESPIRATORY DISTRESS SYNDROME DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 6HR 54MIN 6HR 54MIN |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 30 DEC , 19 66 , to 31 DEC , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 31 DEC , 19 66 , and that death occurred at 2:09M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Phillip Steiner</i> | | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> A.M. STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 31 DEC 1966 |
| 22c. PHYSICIAN'S NAME (Type) PHILLIP STEINER, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | 23b. DATE THEREOF 3 Jan 67 | 23c. NAME OF CEMETERY OR CREMATORY D.C. MORGUE | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. |
| 24. FUNERAL DIRECTOR <i>Charles Judge</i> | | 25a. REC'D BY REGISTRAR DATE JAN 9 1967 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17587

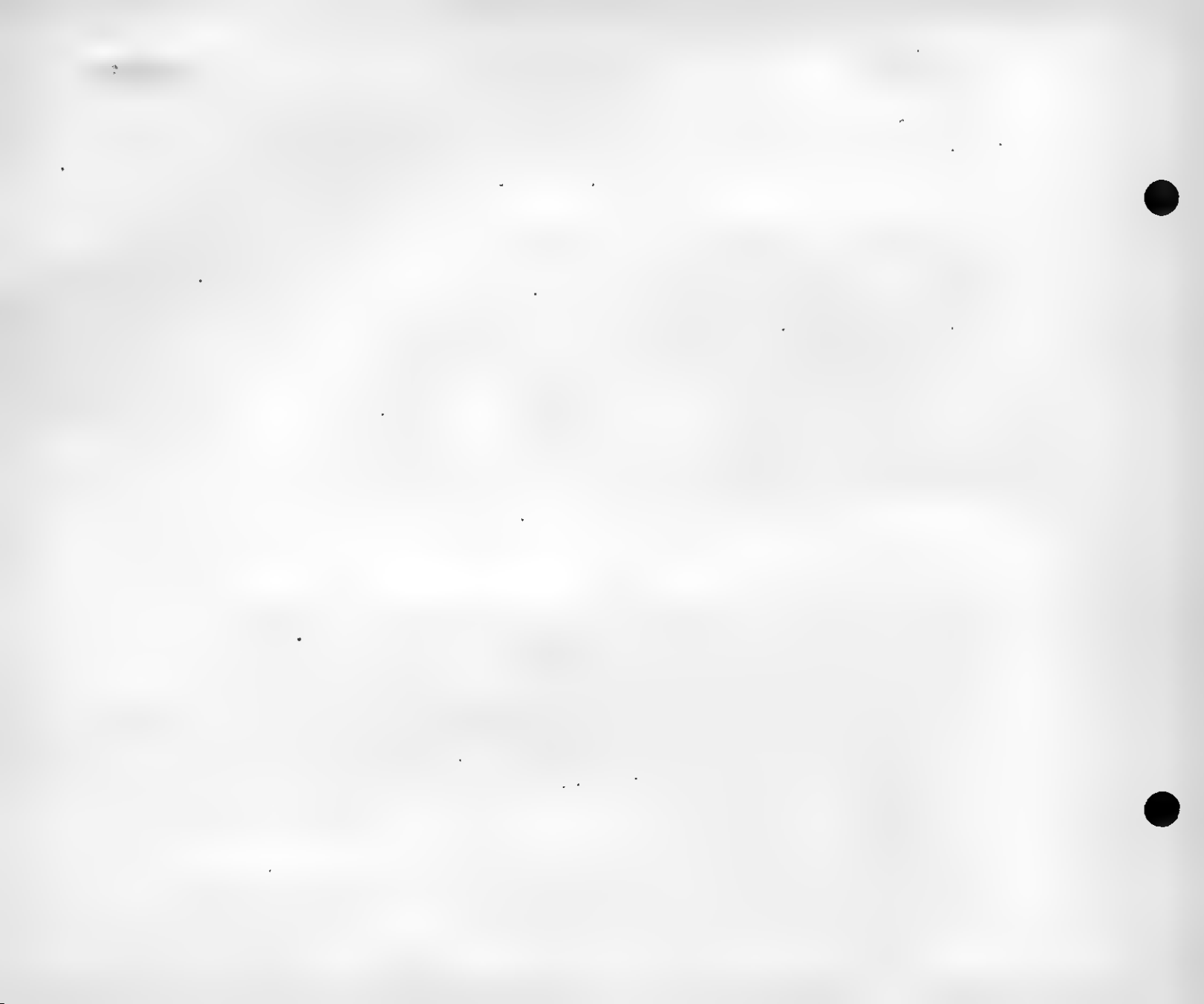
CERTIFICATE OF DEATH

17579

| | | | | | | | |
|---|--|---|---|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b 3 wks. 4 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | | d. STREET ADDRESS 10 D Southway | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Theresa Bower | | | | 4 DATE OF DEATH Month Dec. Day 25 Year 19 66 | | | |
| 5 SEX Female | | 6 COLOR OR RACE Cauc. | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 6-4-65 | |
| 9. AGE (In years last birthday) 1 1/2 yrs. | | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --- | | 10b KIND OF BUSINESS OR INDUSTRY --- | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | | 13. FATHER'S NAME Edward H Bowers | | | |
| 14. MOTHER'S MAIDEN NAME Judith A Laws | | | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) --- | | | |
| 16. SOCIAL SECURITY NO --- | | | | 17. INFORMANT Edward H Bower | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY. 3.103 IMMEDIATE CAUSE (a) MENINGITIS (UNDETERMINED ETIOLOGY) DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2) PNEUMONITIS 3) R. OTITIS MEDIA | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 12-19, 19 66 to 12-25, 19 66 , that (I) (we) last saw the deceased alive on 12-24, 19 66 and that death occurred at 4:30 A. M. from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE Albert Roth | | | | 22b. ADDRESS Riverdale, Md. | | 22c. DATE SIGNED 12/25/66 | |
| 22c. PHYSICIAN'S NAME (Type) Albert Roth | | 22d. ADDRESS Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 27, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington D C | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DEC 29 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



17588

CERTIFICATE OF DEATH

17580

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|--|--|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN 1b D.O.A. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6906 B St., Seat Pleasant, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 6906 B St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle R. Last Boyer | | | | 4. DATE OF DEATH Month December Day 2 Year 19 66 | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Jan. 25, 1915 | | |
| 9. AGE (In years last birthday) 54 yrs | | 10. FUND 1 YEAR Months 2 Days 1 | | 11. IF UNDER 24 HRS. Hours 1 Min. 15 | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles Crider | | | | 14. MOTHER'S MAIDEN NAME ? Horner | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Robert D. Boyer 6906 B St. Seat Pleasant Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Myocardial Infarction 120.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 1/2 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1400 , 19 11/30 , to 12/1 , 19 66 ; that (I) (we) last saw the deceased alive on 11/30 , 19 66 , and that death occurred at 2:20 P.M. from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE Peter Duus | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/2/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Duus, Peter, M.D. | | | 22d. ADDRESS 6124 Central Ave., Captiol Hgts, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/5/66 | | 23c. NAME OF CEMETERY OR CREMATORY Edge Hills Cemetery | | 23d. LOCATION (City or Town) (County) (State) Charles Town, West Virginia | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Road, Suitland Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 6 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17589

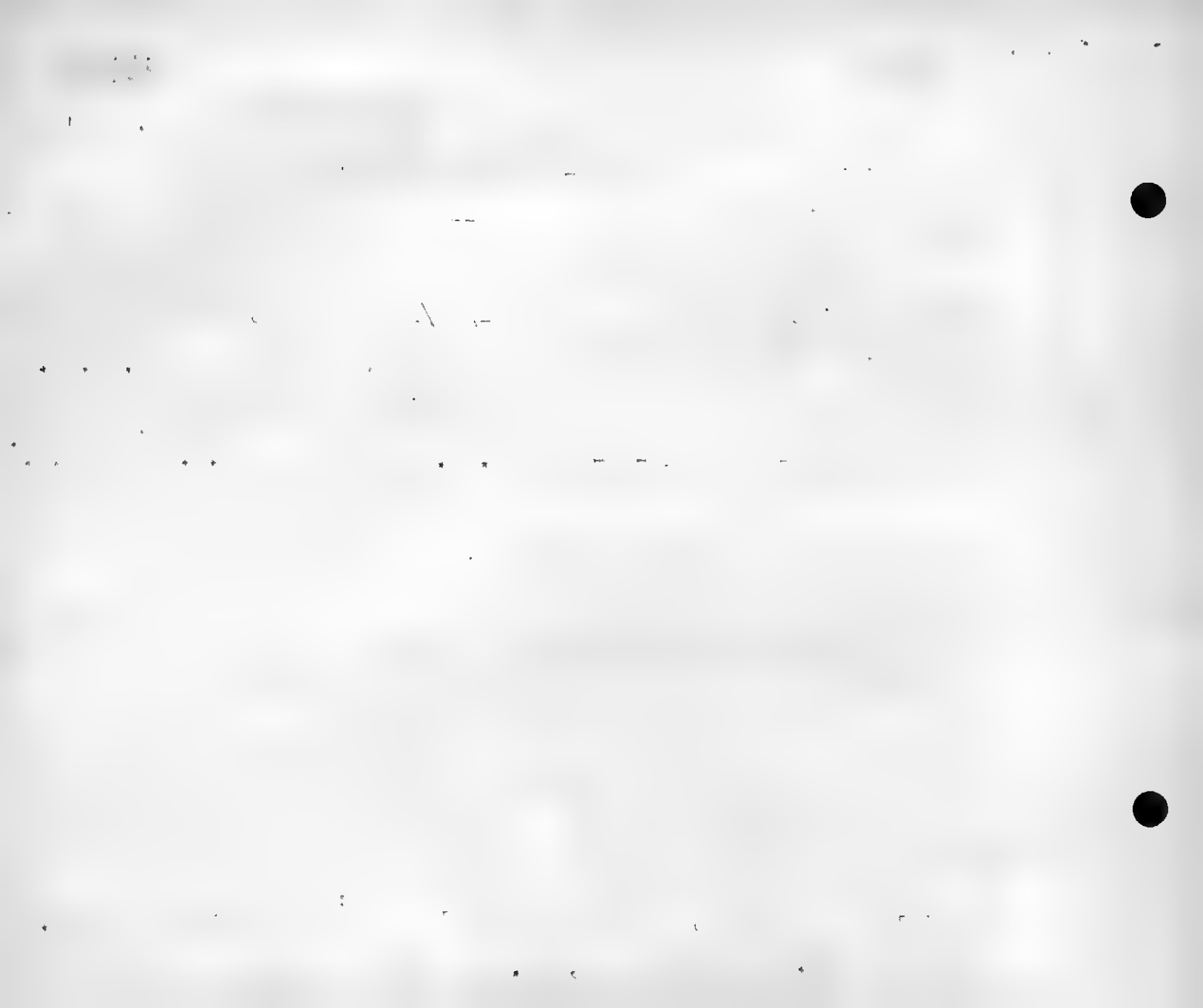
CERTIFICATE OF DEATH

17581

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN ib 6 Mos-15 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Alma First Josephine Middle Brady Last | | 4. DATE OF DEATH Month 12 Day 27 Year 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/23/1880 |
| 9. AGE (In years last birthday) 86 yrs | | IF UNDER 1 YEAR Months Days Hours Mins. | |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Groome, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME William Beall | | 14. MOTHER'S MAIDEN NAME Henrietta Elizabeth Hardy | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 217-46-5334 | |
| 17. INFORMANT 7005 Ritchie Rd. Dr. W. Suit Ritchie-S.E. Wash 27, D.C. | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerosis, Generalized DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 wk. 16 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) Embolus Left Femoral Artery 12 hrs | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6-11 , 19 66 , to 12-27 , 19 66 , that (I) (we) last saw the deceased alive on 12-26 , 19 66 , and that death occurred at 5:30 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE W.B. Shear M.D. | | 22b. DATE SIGNED 12-27-66 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER B. SHEAR, M.D. | | 22d. ADDRESS 6450 MARLBORO PIKE S.E. WASH. 20028, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/29/66 | 23c. NAME OF CEMETERY OR CREMATORY Methodist Church Com. Forest Memorial | 23d. LOCATION (City or Town) (County) (State) Forestville Md. |
| 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 6 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

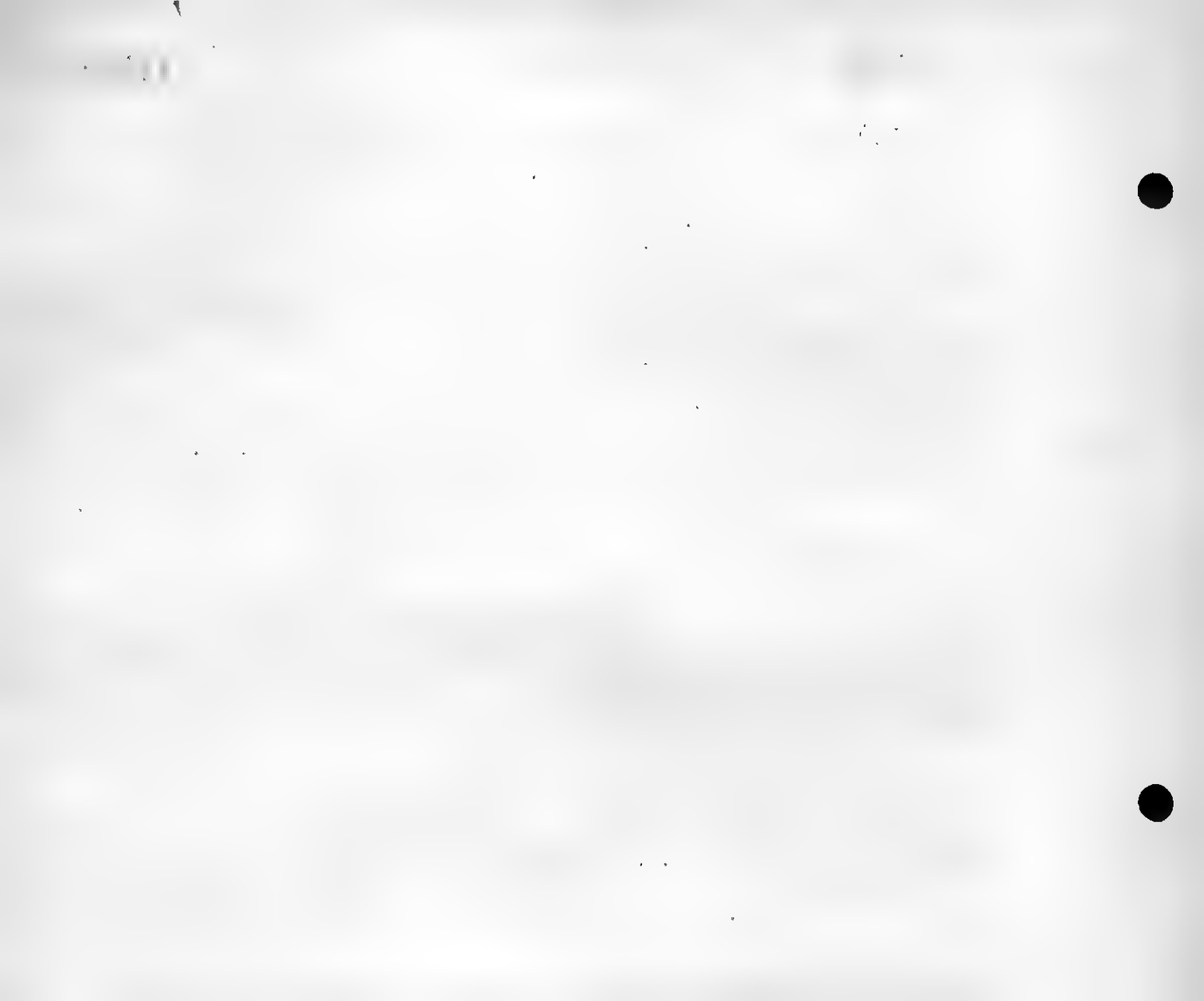
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17590

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17582

| | | | | | |
|--|--|--|---|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clewerly</u> | | c. LENGTH OF STAY IN 1b <u>30 min.</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George Hos.</u> | | | d. STREET ADDRESS <u>12007 White Hall Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) <u>Leo Joseph Brett</u> | | | 4 DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1966</u> | | |
| 5 SEX <u>M</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1 May 1898</u> | | 9 AGE (In years last birthday) yrs <u>68</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired detective</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | 11 BIRTHPLACE (State or foreign country) <u>New Jersey</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U S A</u> |
| 13 FATHER'S NAME <u>Joseph F. Brett</u> | | | 14 MOTHER'S MAIDEN NAME <u>Mary Mitchell</u> | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW I</u> | | 16 SOCIAL SECURITY NO <u>072 05 9484</u> | 17 INFORMANT <u>Maryon G Brett</u> <u>Bowie, Md.</u> Address | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>622X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Unknown</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Aneurysm of thoracic aorta</u> | | | | | 19 WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>John H. Kelly</u> M.D. | | CHIEF MED. CAL. EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED <u>12-25-66</u> | |
| EXAMINER'S NAME (Type) <u>John H. Kelly, M.D., Riverdale</u> | | ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/> | | DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec 28, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Wallkill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Phillipsburg New York</u> |
| 24 FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | | 25a. REC'D BY REGISTRAR <u>DEC 28 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



17591

CERTIFICATE OF DEATH

17583

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment in any event, within 72 hours after death.

| | | | | | | | |
|--|---------------------------------|---|--------------------------------------|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>SILVER SPRING</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | c. LENGTH OF STAY IN 1b <u>16 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CARROLL MANOR</u> | | | | d. STREET ADDRESS <u>2106 DEXTER AVE.</u> | | | |
| 3 NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>E</u> Last <u>BREWER</u> | | | | 4 DATE OF DEATH Month <u>DEC.</u> Day <u>13</u> Year <u>1966</u> | | | |
| 5 SEX <u>FEM</u> | 6 COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>12/13/1891</u> | 9 AGE (In years last birthday) <u>75</u> yrs | IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u> | | IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.</u> | |
| 13. FATHER'S NAME <u>THEODORE A. BURNS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH MCBRAY</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16 SOCIAL SECURITY NO. <u>213-38-6846</u> | | 17. INFORMANT <u>SR. CHRISTINE CARROLL MANOR</u> | | Address | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO (b) <u>HYPERTENSIVE ARTERIOSCLEROTIC</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from causes on and on the date stated above. | | | | | | | |
| 22a SIGNATURE <u>Bernard A. Fitzgerald</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12-14-66</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u> | | | | 22d ADDRESS <u>217 UNIV. BLVD. E. SILVER SPRING, MD.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>17 Dec. 1966</u> | | 23c NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u> | | 23d LOCATION (City or Town) (County) (State) <u>SILVER SPRING MD.</u> | |
| 24 FUNERAL DIRECTOR <u>Rinaldi Funeral Home, Inc. 7400 Georgia Ave.</u> | | | | 25a. REC'D BY REGISTRAR <u>DC 20012</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film 3-3 1-13/66 mh

CERTIFICATE OF DEATH

17592

17584

| | | | | | | | |
|---|-------------------------------|--|---|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pro Georges</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville Md.</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4111 East West Highway</u> | | | | d. STREET ADDRESS <u>4111 East West Highway</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth F. Brueckner</u> | | | | 4. DATE OF DEATH <u>Dec 7 1966</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 6, 1889</u> | 9. AGE (In years last birthday) <u>77 7/77 yrs</u> | 10. IF UNDER 1 YEAR | | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Alan Foley</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Bundy</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>579-28-1938</u> | | 17. INFORMANT <u>Arthur L Brueckner Hyattsville Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the colon</u> DUE TO (b) <u>with metastasis to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>liver</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>arteriosclerotic heart disease</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>66</u> , to <u>12/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/6</u> , 19 <u>66</u> , and that death occurred at <u>2:30 A.M.</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>S.W. Nealson Jr</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12/7/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>S.W. NEALON, JR</u> | | | | 22d. ADDRESS <u>1746 Rte NW Washington D.C.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u> | | 23b. DATE THEREOF <u>Dec 9, 1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Mausoleum</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u> | |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 8 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



17593

CERTIFICATE OF DEATH

17585

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb East Riverdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Adsocorda Nursing Home | | d. STREET ADDRESS 5515 Kennedy Street | |
| 3. NAME OF DECEASED (Type or print) CONSTANCE F. BUTTERS | | 4. DATE OF DEATH Dec. 10, 1966 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 AGE (in years last birthday) yrs 57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafe Helper | | 10b. KIND OF BUSINESS OR INDUSTRY School | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph Butters Parcheski | | 14. MOTHER'S MAIDEN NAME Poreda Frances S. Pareda | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 025 05 3543 | |
| 17. INFORMANT George K. Butters Same as #2 (husband) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 192.0 Glioma of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | INTERVAL BETWEEN DEATH AND TIME OF REPORT over 6 Months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dec 2 | 20f. (City or town) (County) (State) Dec 10, 1966 |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 2 , 19 66 , to Dec 10 , 19 66 , that (I) (we) last saw the deceased alive on Dec 9 , 19 66 , and that death occurred at 11:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>John Kehoe</i> | | 22b. DATE SIGNED 12/10/66 | |
| 22c. PHYSICIAN'S NAME (Type) John Kehoe, M.D. | | 22d. ADDRESS 6300 Riverdale Road Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/13/66 | 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven | 23d. LOCATION (City or Town) (County) (State) Rockville Montgomery Md. |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 15 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17594

CERTIFICATE OF DEATH

17587

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills | |
| c. LENGTH OF STAY IN 1b 15 days | | d. STREET ADDRESS 7701 Arshert Drive | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Edward Middle S Last Cauffman | | 4. DATE OF DEATH Month Dec. Day 15 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH 13 Mar., 1902 |
| 9. AGE (in years last birthday) 64 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME XXXXXXXXXXXX HOWARD CAUFFMAN | | 14. MOTHER'S MAIDEN NAME ANNIEBELL PIERCE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Pulmonary Insufficiency 165X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung DUE TO (c) Pulmonary Edema | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/1/66 , 19 66 to 12/15 , 19 66 that (I) (we) last saw the deceased alive on 12/15 , 19 66 , and that death occurred at 2:45 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edwin J. Jensen M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D. | | 22d. ADDRESS Prince Geo. Gen. Hosp., Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12/17/66 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | 23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND |
| 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUTLAND RD, SUTLAND MD. | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17595

17588

| | | | | | | | |
|--|---------------------------|---|------------------------------|--|--|---|----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE — b. COUNTY — | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY in 1b 40 minutes | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington D.C. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 1724 Corcoran St., N.W. | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Alfred Ernio Cavicchia | | | | 4. DATE OF DEATH Month Day Year 12 6 1966 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11-13-42 | 9. AGE (in years last birthday) 24 yrs. | 10. FUNDER 1 YEAR 11. FUNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical | | 10b. KIND OF BUSINESS OR INDUSTRY student | | 11. BIRTHPLACE (State or foreign country) New York City | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Ennio Cavicchia | | | | 14. MOTHER'S MAIDEN NAME Brigid Dia | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 059 34 2325 | | 17. INFORMANT Lynni H Cavicchia New York City N Y | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple skull fractures DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) driver of car involved in collision | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:01 p.m. 12-5 1966 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Routes 301 & 381 | | 20f. (City or town) (County) (State) Prince George's, Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | | | 22. DATE SIGNED 12-6-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 10, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Moravian Cemetery | | 23d. LOCATION (City, town or county) (State) Staten Island New York. | |
| 24. FUNERAL DIRECTOR F. Gaschs Sons | | | | 25a. REC'D BY REGISTRAR DATE DEC 8 1966 | | | |
| ADDRESS Hyattsville, Md. | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



17596

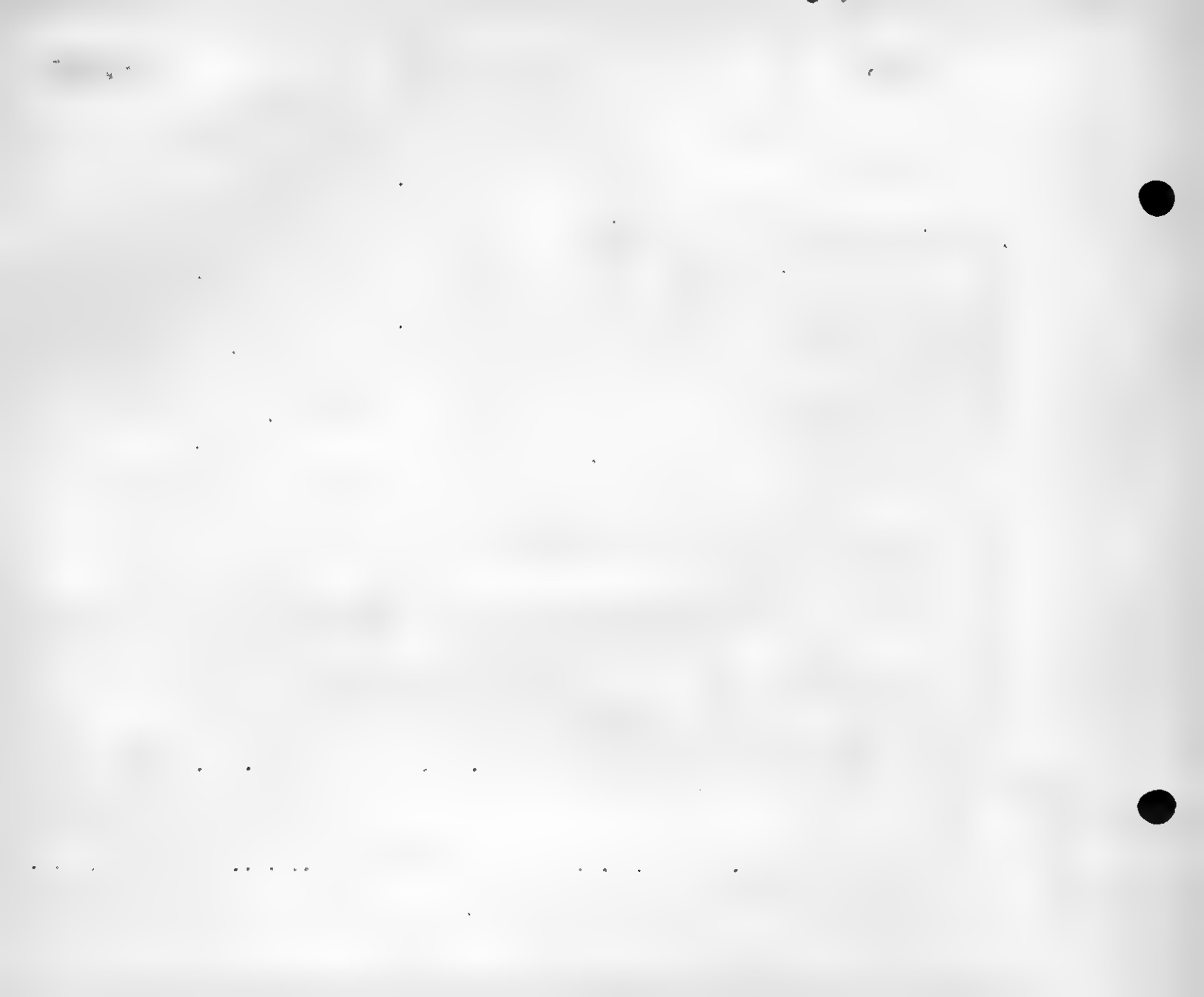
CERTIFICATE OF DEATH

17589

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 1 day | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 4501 32nd Street | |
| 3. NAME OF DECEASED (Type or print) First Lester Middle E Last Cherry | | 4. DATE OF DEATH Month Dec. Day 27 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11 Sept., 1903 |
| 9. AGE (In years last birthday) 63 yrs | | 10. IF UNDER 1 YEAR Months 63 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H/W | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Durham, North Carolina | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Jerome Freeman | | 14. MOTHER'S MAIDEN NAME Lottie Holder | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unk. | |
| 17. INFORMANT Doyle E. Cherry | | 18. ADDRESS 4501 32nd Street Mt. Rainier, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE Emphysema & mucois plugging of bronchioles DUE TO (b) Status Asthmaticus DUE TO (c) asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1966 , to Dec. 28, 1966 that (I) (we) last saw the deceased alive on Dec. 28, 1966 , and that death occurred at 4:25 P.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE Robert T. Kelley | | 22b. DATE SIGNED 12/28/66 | |
| 22c. PHYSICIAN'S NAME (Type) Robert T. Kelley, M.D. | | 22d. ADDRESS 1026 16th St., N.W., Washington, D.C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial | 23b. DATE THEREOF 12/31/66 | 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial | 23d. LOCATION (City or Town) (County) (State) Durham, North Carolina |
| 24. FUNERAL DIRECTOR MURPHY FUNERAL HOME John C. Thomas | | 25a. REC'D BY REGISTRAR DEC 30 1966 DATE | 25b. REGISTRAR'S SIGNATURE W. H. Hodge |



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17598

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Maryland Park | |
| c. LENGTH OF STAY IN lb 5 Hrs. | | d. STREET ADDRESS 6503 C. Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last William A Chisholm | | 4. DATE OF DEATH Month Day Year 12 7 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH 28 Nov. 1887 |
| 9. AGE (in years last birthday) 79 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Minn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Angus Chisholm | | 14. MOTHER'S MAIDEN NAME Elizabeth Quigley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 468-14-8005A | |
| 17. INFORMANT Margaret C. Chisholm | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Nutritional cirrhosis of liver with hepatic failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 12-9-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF Dec. 13, 1966 | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | 23d. LOCATION (City, town or county) (State) Minneapolis, Minn. |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300 4th St. Ne. Wash. | | 25a. REC'D BY REGISTRAR DEC 14 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | D.C. | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

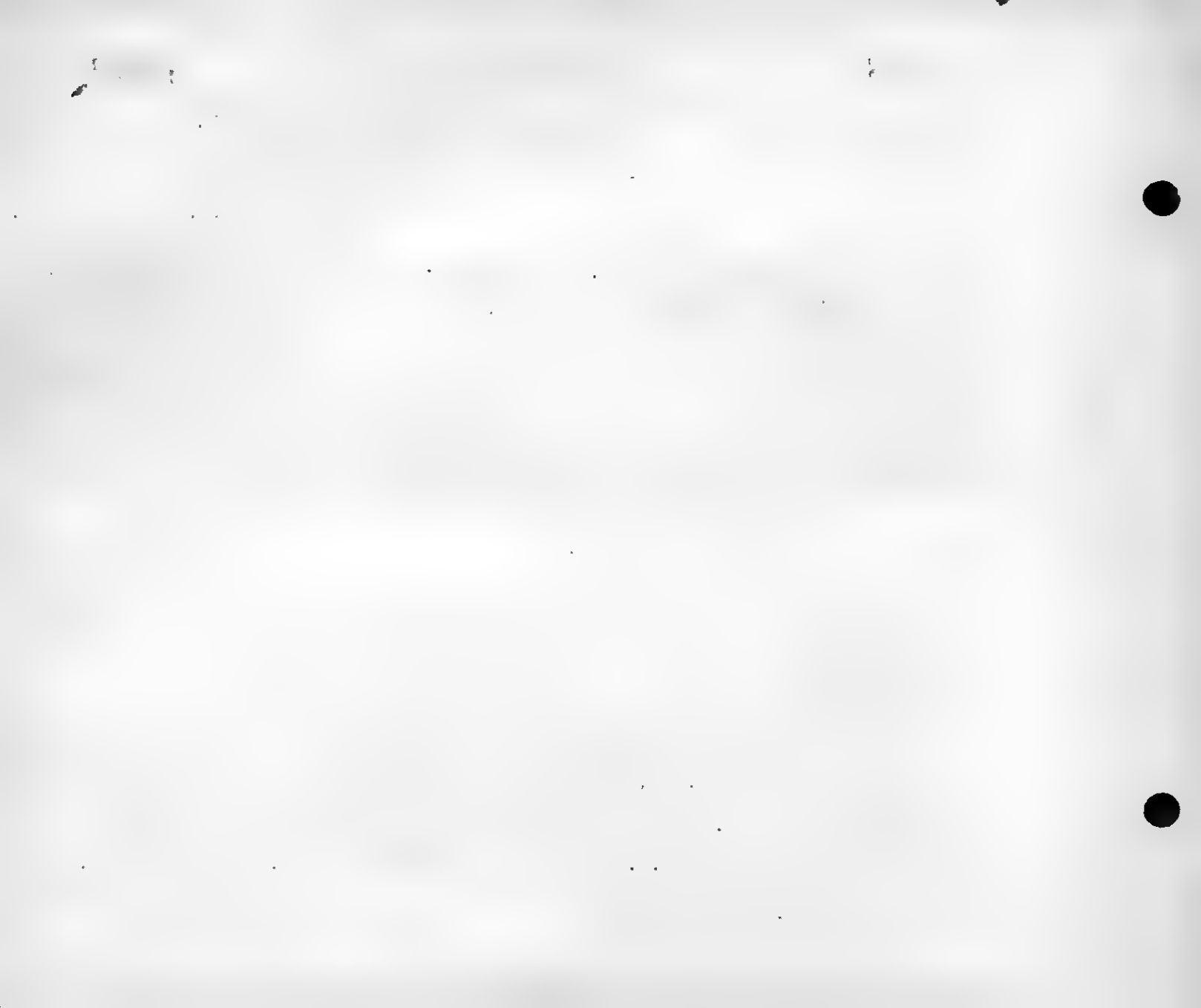
17598

CERTIFICATE OF DEATH

17591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 19 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE District of Columbia b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) =Washington, D. C. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | d. STREET ADDRESS 2806 Channing St., N.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First Middle Last Horace R. Clopton | | | 4. DATE OF DEATH Month Day Year December 27 1966 | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/22/18 | | 9 AGE (in years) last birthday 48 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) N.C. | |
| 13. FATHER'S NAME Arthur Clonton | | | 14. MOTHER'S MAIDEN NAME Mattie Baker | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Clydie Clopton Same as 2d | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral severe pulmonary congestion & edema DUE TO (b) Hepatic failure DUE TO (c) Severe nutritional fatty cirrhosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. ((City or town) (County) (State)) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 66 , to Dec. 27 , 19 66 , that (I) (we) last saw the deceased alive on Dec. 27 , 19 66 , and that death occurred at 12:20 M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Till Bergemann | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/28/66 | |
| 22c. PHYSICIAN'S NAME (Type) Till Bergemann, M.D. | | 22d. ADDRESS Professional Bldg., Greenbelt, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-31-66 | 23c. NAME OF CEMETERY OR CREMATORY Sun Set Mem. Co. | 23d. LOCATION (City or Town) (County) (State) Henderson, N.C. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D. BY REGISTRAR DATE DEC 30 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17599

17592

| | | | | | | | |
|--|--|--|--------------------------------|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DCA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS RFD Box 2085 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Angela Renea Colbert | | | 4 DATE OF DEATH 12 21 19 66 | | 5 SEX Female 6 COLOR OR RACE Negro 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH 7-12-66 9. AGE (In years last birthday) Yrs 5 Months 5 Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME James Colbert | | | | 14 MOTHER'S MAIDEN NAME Sadie Belt | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO None | | 17 INFORMANT Address James Colbert Upper Marlboro, Md. | | | |
| 18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 491X Broncho pneumonia, right upper lobe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) SDII DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. Riverdale, Md. | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22 DATE SIGNED 12-22-66 | |
| 23a. BURIAL, CREMATION, REMOVAL, (Specify) | | 23b. DATE THEREOF 12-24-66 | | 23c. NAME OF CEMETERY OR CREMATORY Moses Cemetery | | 23d. LOCATION (City or Town) (County) (State) Anne Arundell, Md. | |
| 24 FUNERAL DIRECTOR Rollins Funeral Home, Inc. pl., N.E. | | | | 25a. REC'D BY REGISTRAR DEC 27 1966 | | 25b. REGISTRAR'S SIGNATURE James Judge | |

6-290234

FOR STATE
HEALTH DEPT.

17600

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 17593

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 3401 15TH STREET S.E. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE 50 MIN | | | | c. LENGTH OF STAY IN 1b 50 MIN | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First GLENIECE | | Middle VENETTA | | Last COLKLEY | | 4. DATE OF DEATH Month DECEMBER Day 4 Year 19 66 | |
| 5. SEX FEMALE | | 6. COLOR OR RACE NEGROID | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 28 JUNE 1965 | |
| 9. AGE (In years last birthday) 1 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | | | |
| 13. FATHER'S NAME HARRY LEE COLKLEY | | | | 14. MOTHER'S MAIDEN NAME LORRAINE REBBECCA NEAL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N/A | | 16. SOCIAL SECURITY NO. N/A | | 17. INFORMANT HARRY L. COLKLEY-FATHER-SAME AS #2 Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8/20 DUE TO Salicylate intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) 8 hrs INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Took overdose of aspirin | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 12-4 19 66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home | | 20f. (City or town) (County) (State) Same as #2 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | M.D. JOHN J KEHOE, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 5 DEC 1966 | |
| EXAMINER'S NAME (Type) JOHN J KEHOE, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 12/8/66 | | 23b. DATE THEREOF 12/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Park | | 23d. LOCATION (City, town or county) (State) Arlington, VA | |
| 24. FUNERAL DIRECTOR W. W. Clendenen | | 577 11 ADDRESS WASH. D.C. | | 25a. REC'D BY REGISTRAR DEC 8 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17601

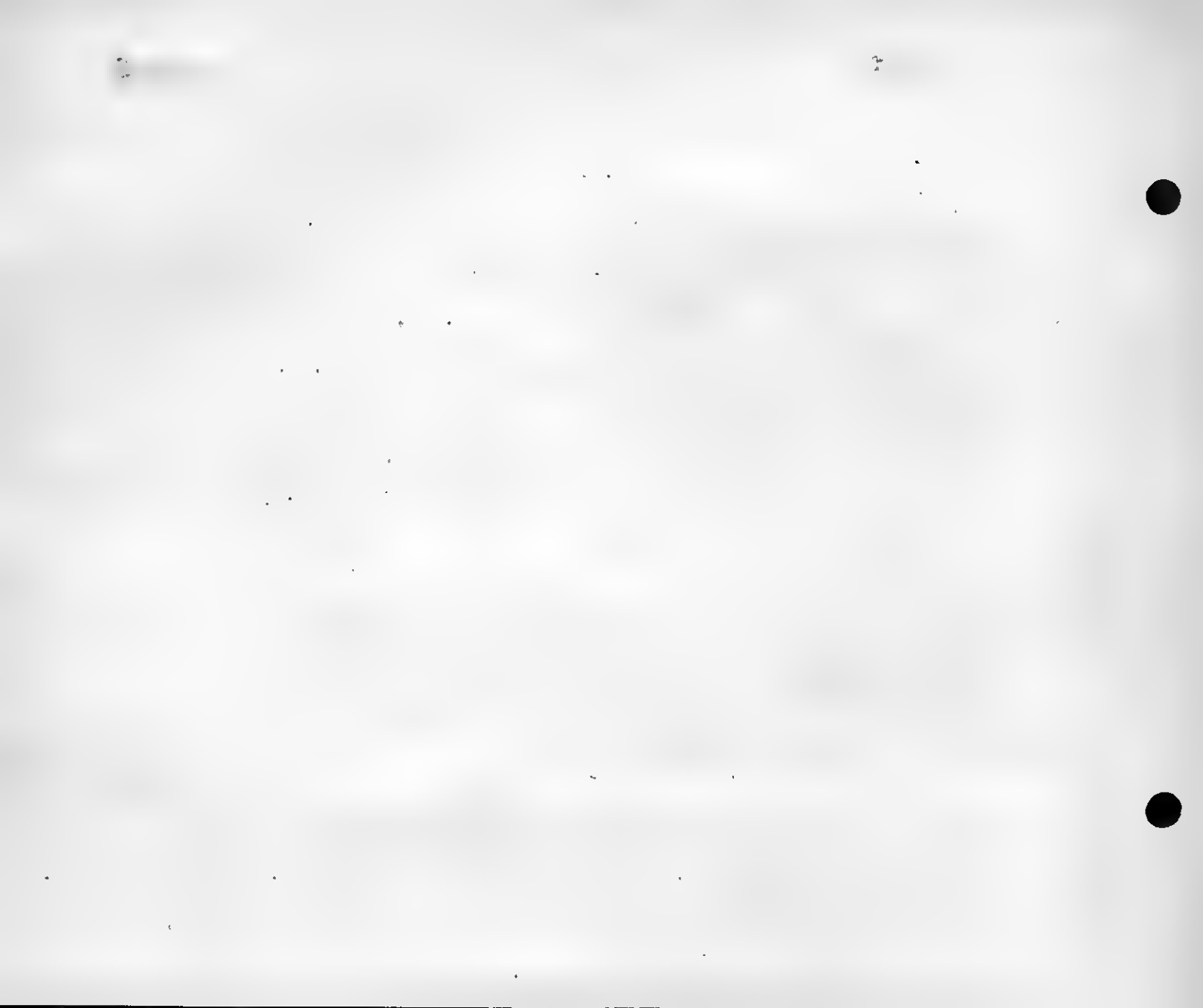
CERTIFICATE OF DEATH

17594

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb D.O.A. | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 4902 F St. | |
| 3. NAME OF DECEASED (Type or print) First John Middle L. Last Compher | | 4. DATE OF DEATH December 17, 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 27, 1901 |
| 9. AGE (In years last birthday) 65 yrs. | | 10. IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William E. Compher | | 14. MOTHER'S MAIDEN NAME Jennie Decator | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Catherine W. Compher | | Address 4902 F Street | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Arteriosclerotic coronary art disease 10 yrs. DUE TO Arteriosclerotic cardiac based disease 10 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 15 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-15 , 19 66 , to 12-17 , 19 66 , that (I) (we) last saw the deceased alive on 12-15 , 19 66 , and that death occurred at 12-17 , 19 66 , M, from causes and on the date stated above. | | | 22b. DATE SIGNED |
| 22a. SIGNATURE Peter Duus | | 22c. PHYSICIAN'S NAME (Type) Peter Duus, M.D. | |
| 22d. ADDRESS 6124 Central Ave., Capitol Hgts., Md. | | 22e. REC'D BY REGISTRAR DEC 21 1966 | |
| 22f. REGISTRAR'S SIGNATURE Charles Judge | | 22g. REGISTRAR'S NAME | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/20/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home | | ADDRESS 4308 Suitland Rd. Suitland Md. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17502 **CERTIFICATE OF DEATH** 17595
Item 8 Film G-504

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH - COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Washington b. COUNTY DC | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hosp | | d. STREET ADDRESS 11 Riggs Rd NE | |
| 3. NAME OF DECEASED (Type or print) Thomas First Middle Last | | 4. DATE OF DEATH Dec 16 1966 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/28/1957 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Retired | |
| 12. BIRTHPLACE (County & State, or foreign country) Wash. D.C. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME John C. | | 14. MOTHER'S MAIDEN NAME Mary Carmody | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Viola Maria Costello (wife) | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Coronary Artery Disease (b) DUE TO Hypertensive Cardiovascular Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1955 to Dec 16, 1966 that (I) (we) last saw the deceased alive on Oct 22 1966 and that death occurred at 11:50 AM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard L. Whelton M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Richard L. Whelton | | 22d. ADDRESS 1017 University Blvd E Springfield VA | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 20, 66 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l | 23d. LOCATION (City, town or county) (State) Arlington VA |
| 24. FUNERAL DIRECTOR Hanton Funeral Home | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| ADDRESS 4747 Wisc Ave NW | | DATE JAN 6 1967 | |

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17603

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17598

| | | | |
|--|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Island Memorial Hospital | | d. STREET ADDRESS 2105 Charlestown Lane | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Cressilda Lillian Crawford | | 4. DATE OF DEATH Month Day Year 12 25 1966 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-8-08 |
| 9. AGE (In years last birthday) yrs 58 | | 10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Transcriber- Nat'l. Geographic | |
| 11. BIRTHPLACE (State or foreign country) Maine | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Howard Murch | | 14. MOTHER'S MAIDEN NAME Lula Bunker | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No. | | 16. SOCIAL SECURITY NO. 577-07-0592 | |
| 17. INFORMANT John D. Crawford, See Item No. 2. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 5 minutes | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | 22. DATE SIGNED 12-25-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-28-1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington, Nat'l. Cem. Arlington, Va. |
| 23d. LOCATION (City or town) (County) (State) | | 23e. RECORD BY REGISTRAR DEC 29 1966 | |
| 24. FUNERAL DIRECTOR Joseph J. Sawyer's Sons, Inc. 3130 Wisconsin Ave. N.W. Wash. DC. | | 25. REGISTRAR'S SIGNATURE Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17504

CERTIFICATE OF DEATH

17597

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. STREET ADDRESS 9412 Buena Vista Ave. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Florence Creighton | | 4. DATE OF DEATH Month Day Year December 15, 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/4/78 |
| 9. AGE (In years last birthday) yrs. 88 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of workable life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Kent Co., Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME William J. Owens | | 14. MOTHER'S MAIDEN NAME Susanna Frederica Sapp | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Dorothy Fastnaught Same as #2 (daughter) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MASSIVE INFARCTION OF MYOCARDIUM (ANT. WALL OF LT VENTRICLE) WITH ANEURYSMAL DILATATION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CORONARY THROMBOSIS (ANT. DESCENDING LT CORONARY) (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 12 , 19 66 , to Dec. 15 , 19 66 , that (I) (we) last saw the deceased alive on Dec. 15 , 19 66 , and that death occurred at 8:50 P.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE Robert T. Kelley, M.D. | | 22b. DATE SIGNED 12/17/66 | |
| 22c. PHYSICIAN'S NAME (Type) Robert T. Kelley, M.D. | | 22d. ADDRESS 1026 16th St., N.W., Washington, D. C. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/19/66 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 23d. LOCATION (City or Town) (County) (State) Suitland P.G. Md. |
| 24. FUNERAL DIRECTOR Leach Funeral Home | | 25a. REC'D BY REGISTRAR DEC 22 1966 | |
| ADDRESS 4739 Balto. Ave. Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17605

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17598

| | | | |
|--|----------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hosp. | | d. STREET ADDRESS 8601 11th St., N.W. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last John Henry Cummings | | 4. DATE OF DEATH Month Day Year 12 22 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 21 Jan., 1925 |
| 9. AGE (In years lost birthday) 41 yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO WORKS | | 11. BIRTHPLACE (State or foreign country) GEORGIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME JOHN H CUMMINGS | |
| 14. MOTHER'S MAIDEN NAME EULA | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT EULA M. CUMMINGS, Address 3601 11th St. N.W. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral hemithorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gunshot wound of chest DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Shot by assailant | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:00 pm 12 22 19 66 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, place, etc.) Parking lot-1701 Kenilworth Ave., P.G., Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 12-23-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12/29/66 | 23c. NAME OF CEMETERY OR CREMATORY Arlington | 23d. LOCATION (City or town) (County) (State) Ft. Myer, Va. |
| 24. FUNERAL DIRECTOR | | 25. REC'D BY REGISTRAR DEC 29 1966 | |
| 26. REGISTRAR'S SIGNATURE | | 27. REGISTRAR'S SIGNATURE | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17606

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17599

| | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution, include before admission) a. STATE Maryland | | | | b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 1 hr. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | | | | | d. STREET ADDRESS 8431 Allendale Drive | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Asa Franklin Davis | | | | 4. DATE OF DEATH Month Day Year 12 24 19 66 | | | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4 April 1905 | | 9. AGE (in years last birthday) 61 yrs | | F UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radio | | | | 10b. KIND OF BUSINESS OR INDUSTRY Repairman | | | | 11. BIRTHPLACE (State or foreign country) North Carolina | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Asa F Davis | | | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1924 to 1928 | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Asa F Davis Jr Palmer Park, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hrs. unknown | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF DEATH Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| 22. DATE SIGNED 12-25-66 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | 23b. DATE THEREOF Dec 27, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | | | 25a. REC'D BY REGISTRAR DEC 29 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17600

17607

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|--|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN IL DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS 5102 Benning Road | | |
| 3. NAME OF DECEASED (Type or print) Thomas James Delaney | | | 4. DATE OF DEATH Month 12 Day 24 Year 19 66 | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-14-1892 | 9. AGE (In years last birthday) 74 yrs | IF UNDER 1 YEAR Months 24 Days 19 Hours 66 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME unknown | | | 14. MOTHER'S MAIDEN NAME unknown | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Beatrice Delaney Address 5102 Benning Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH minutes over 1 yr. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | 22. DATE SIGNED 12-26-66 | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/29/66 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme. | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home | | 24a. RECORD BY REGISTRAR DEC 30 1966 | | 25a. REGISTRAR'S SIGNATURE [Signature] | |
| 23d. LOCATION (City or town) (County) (State) Maryland | | 23e. LOCATION (City or town) (County) (State) | | | |



17608

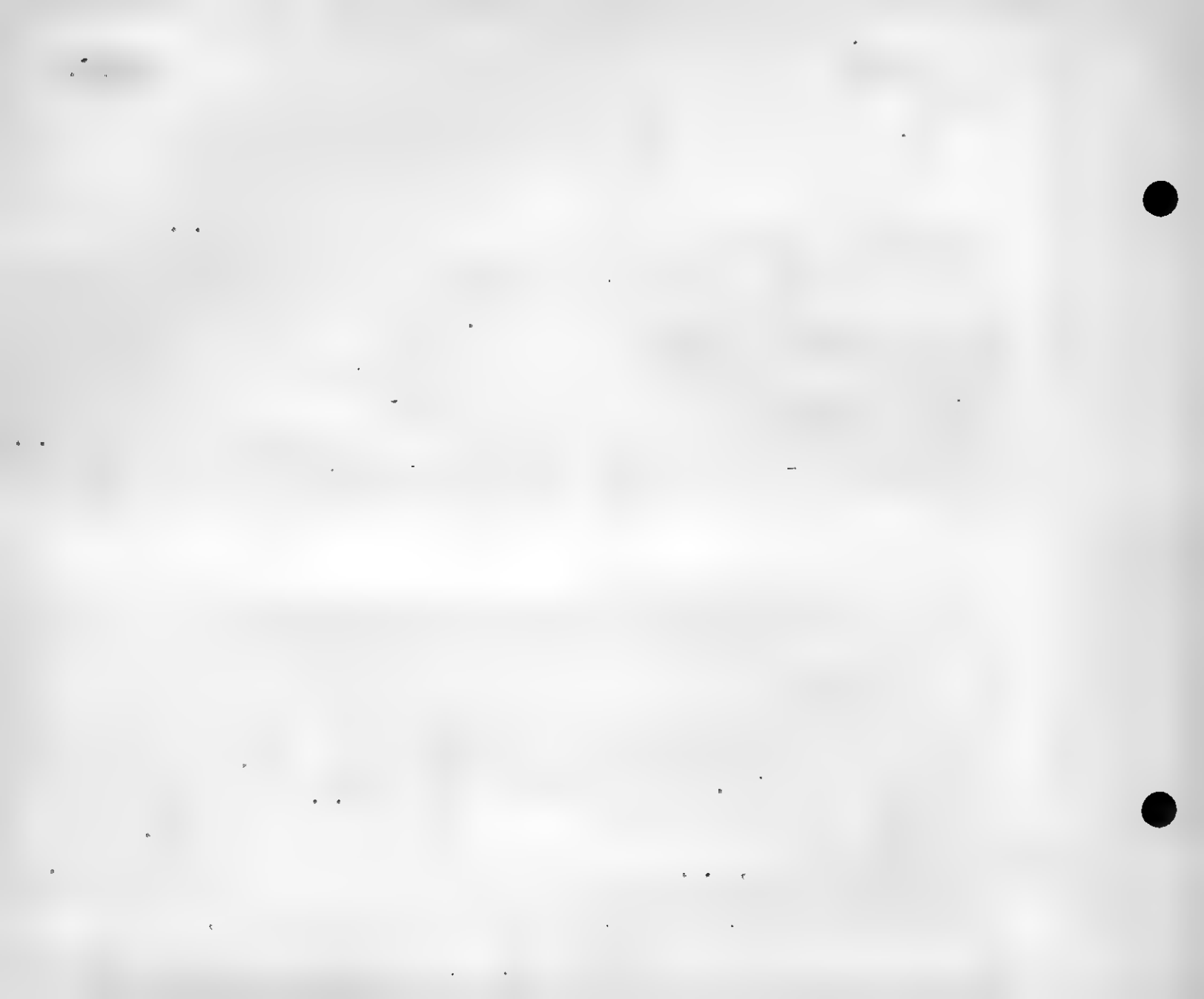
CERTIFICATE OF DEATH

17601

| | | | |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE District of Columbia b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Glenn Dale) | | c. LENGTH OF STAY IN lb 26 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | d. STREET ADDRESS 402 Jefferson Street, N.E. | |
| 3 NAME OF DECEASED (Type or print) Jerry A. Disandro | | 4 DATE OF DEATH Month December Day 11 Year 19 66 | |
| 5 SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Jan. 1, 1914 |
| 9 AGE (In years lost birthday) 52 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) waiter | |
| 10b KIND OF BUSINESS OR INDUSTRY Hotel | | 11 BIRTHPLACE (County & State, or foreign country) Foreign born (unknown) | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Gioeinto Disandro | |
| 14. MOTHER'S MAIDEN NAME Susanna ? | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) unknown | |
| 16 SOCIAL SECURITY NO. unknown | | 17 INFORMANT Brother - Raymond Disandro | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 21 Pulmonary Tuberculosis, Far Advanced DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN DEATH AND DEATH Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) generalized arteriosclerosis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21 I certify that (I) (this hospital) attended the deceased from Nov. 15 , 19 66 , to Dec. 11 , 19 66 , that (I) (we) last saw the deceased alive on Dec. 11 , 19 66 , and that death occurred at 12:10 M. from causes and on the date stated above. | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | 22b. DATE SIGNED Dec. 11, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 14 Dec. 1966 | |
| 23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington, DC | |
| 24 FUNERAL DIRECTOR Rinaldi Funeral Home 7400 Georgia Ave., N.W. | | 25a. REC'D BY REGISTRAR DEC 14 1966 | |
| 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17609

CERTIFICATE OF DEATH

17602

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 27 MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE CEDARVILLE MOBILE HOME PARK d. STREET ADDRESS CEDARVILLE MOBILE HOME PARK e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) CARYLON LYNN DIXON | | 4. DATE OF DEATH Month December 31 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 31 DEC 1966 |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S MARYLAND U.S.A. |
| 13. FATHER'S NAME THOMAS JAMES DIXON | | 14. MOTHER'S MAIDEN NAME CHUNG SUK KIM | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO N/A | 17. INFORMANT THOMAS J DIXON-FATHER-SAME AS #2 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 776X IMMEDIATE CAUSE (a) <u>PREMATURITY</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH 27 MIN |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that XX (this hospital) attended the deceased from 31 DEC, 1966, to 31 DEC, 1966, that X (we) last saw the deceased alive on 31 DEC, 1966, and that death occurred at 7:15 M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <i>Roger E Spitzer</i> | | 22b. DATE SIGNED 31 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) ROGER E SPITZER, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 5 JAN. 1967 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | 23d. LOCATION (City or town) (County) (State) ARLINGTON, VIRGINIA |
| 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUITLAND ROAD, SUITLAND MD. | | 25a. REC'D BY REGISTRAR DATE JAN 9 1967 | 25b. REGISTRAR'S SIGNATURE <i>W. J. Judge</i> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17610

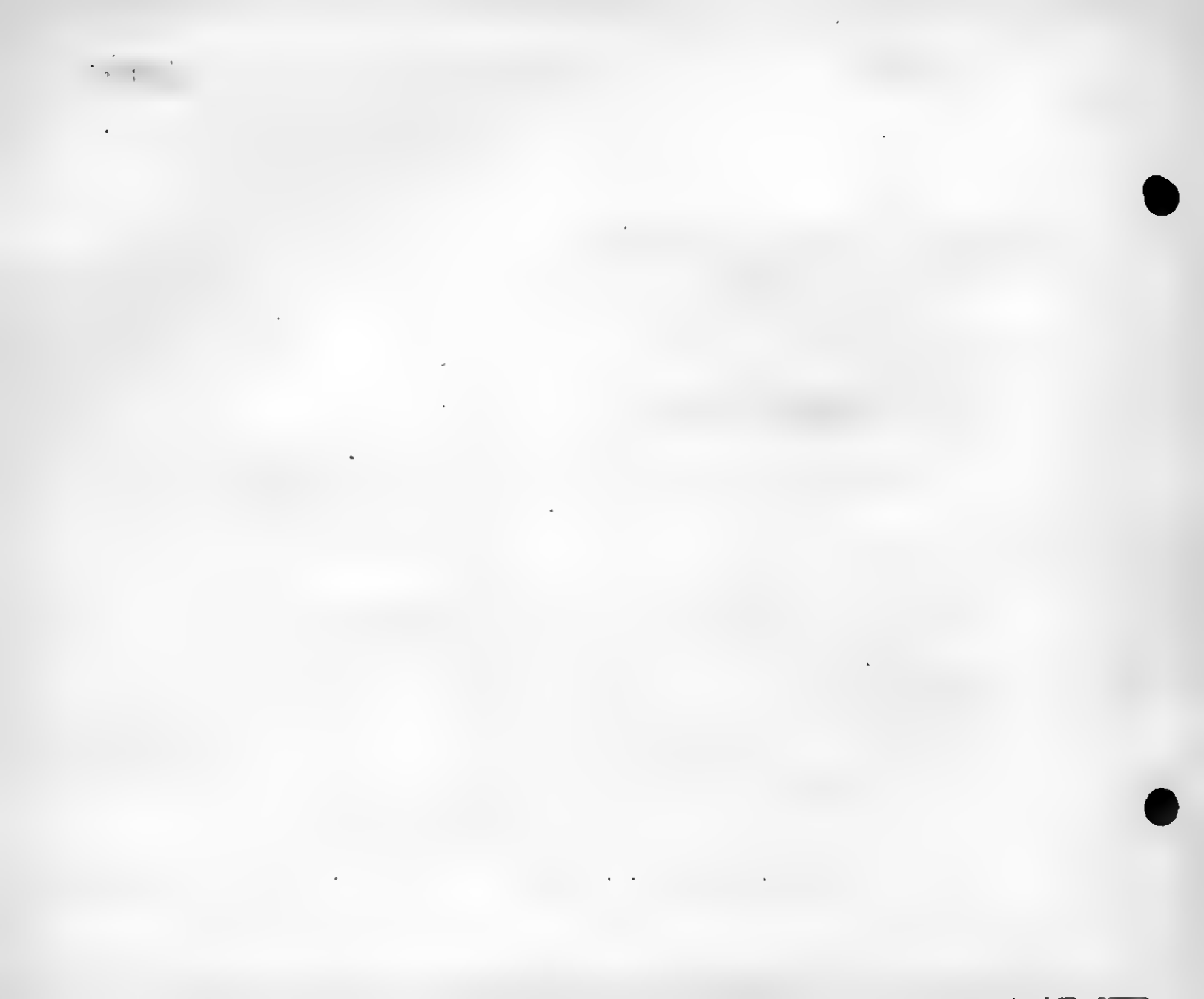
CERTIFICATE OF DEATH

17603

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb 10 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine d. STREET ADDRESS 61 Gibbons Church Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Viola First Elizabeth Middle Elizabeth Last Driver | | 4. DATE OF DEATH Month December Day 15 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 30, 1914 |
| 9. AGE (In years, last birthday) 52 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 15 Hours 19 Min 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Mobile, Alabama | |
| 11. BIRTHPLACE (County & State or foreign country) Mobile, Alabama | | 12. CITIZEN OF WHAT COUNTRY? Unknown | |
| 13. FATHER'S NAME William Greeme | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO 4201 | |
| 17. INFORMANT Charles Driver, Jr. | | Address 1823 Bay St. S.E. Wash. D.C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest. Possible myocardial Infarction DUE TO (b) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Prob. Acute Cholecystitis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prob. Acute Cholecystitis | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12/14 , 19 66 , to 12/15 , 19 66 , that (I) (we) last saw the deceased alive on 12/15 , 19 66 , and that death occurred at 6 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Edwin J. Jensen | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Edwin J. Jensen, M.D. | | 22d. ADDRESS Prince Geo. General Hospital, Cheverly | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 19-66 | 23c. NAME OF CEMETERY OR CREMATORY Gibbons Church Cem. Brandywine, Md. | 23d. LOCATION (City or Town) (County) (State) Brandywine, Md. |
| 24. FUNERAL DIRECTOR Matell Adams Aquasco, Md. | | 25a. REC'D BY REGISTRAR DEC 23 1966 | |
| 25b. REGISTRAR'S SIGNATURE Wesley Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

17611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17604

| | | | | | | | |
|--|--------------------------|--|-----------------------------|--|---|---|---------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 2003 Ingraham Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Dominic | | First Middle Last Falcone | | 4 DATE OF DEATH 12 15 19 66 | | Month Day Year | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9-9-1906 | 9 AGE (In years last birthday) 60 yrs | 10 IF UNDER 1 YEAR Months Days Hours Min | | 11 IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY bakery | | 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 3 FATHER'S NAME Jessie Falcone | | | | 14 MOTHER'S M A DEN NAME Rosa Di Rocco | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. 578 09 2260 | | 17 INFORMANT Emma M Falcone Nyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Acute pulmonary edema, bilateral - severe DUE TO (b) Bronchopneumonia, early, bilateral DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month Day Year Hour o m p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | |
| 22. DATE SIGNED 12-16-66 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 19, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24 FUNERAL DIRECTOR E. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17612

CERTIFICATE OF DEATH

17605

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 35 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. STREET ADDRESS 5408 39th Ave. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last William T Fall | | 4. DATE OF DEATH Month Day Year Dec., 15 1966 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 15 Dec., 1882 |
| 9 AGE (In years last birthday) 84 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Photographer | |
| 11 BIRTHPLACE (County & State, or foreign country) Philadelphia Pa | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William Fall | | 14. MOTHER'S MAIDEN NAME Margaret Miller | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 577 05 8290A | |
| 17. INFORMANT Elen K Fall | | Address Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO (b) Phlebotomiasis DUE TO (c) Prostatic Hypertrophy - Surgery - Azotemia INTERVA. BETWEEN ONSET AND DEATH 12/6/66 11/11/66 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 59 , to 12/14 , 19 66 , that (I) (we) last saw the deceased alive on 12/14 , 19 66 , and that death occurred at 4.00AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Gordon W Kelley M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Gordon Kelley, M.D. | | 22d. ADDRESS 6124 16th St., Hyattsville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 17, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DATE DEC 19 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of, and in any event, within 72 hours after death.

17613

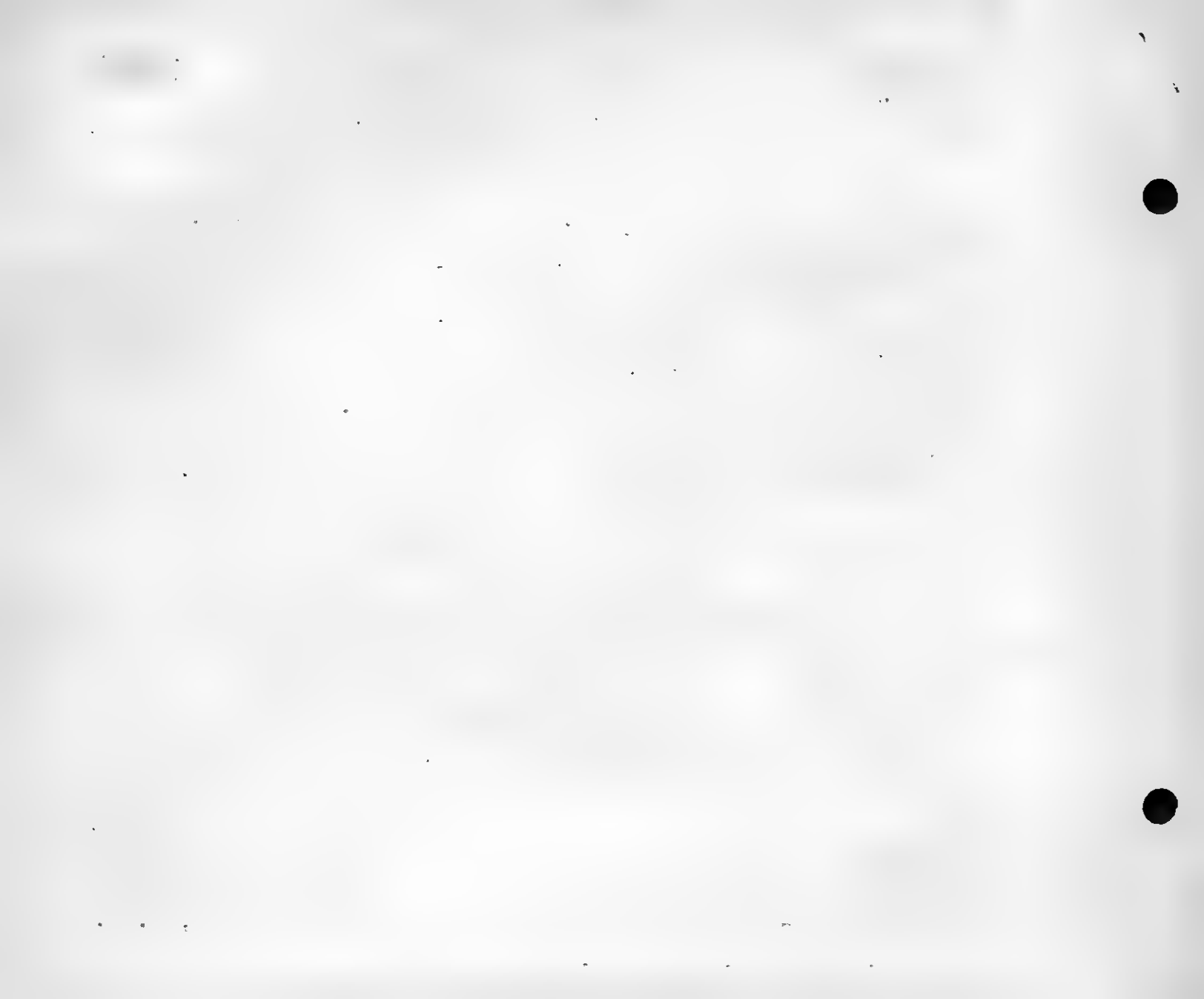
CERTIFICATE OF DEATH

17606

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY PRINCE GEORGE COUNTY MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi | | c. LENGTH OF STAY IN 1b 2 1/2 mos. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PAINT BRANCH NURSING HOME | | d. STREET ADDRESS 3720 Alton Place, N. W. | |
| 3 NAME OF DECEASED (Type or print) GEORGE PETER FIELDS | | 4. DATE OF DEATH Month DEC Day 23 Year 1966 | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 1-12-1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) DRAFTSMAN | | 10b. KIND OF BUSINESS OR INDUSTRY DRAFTSMAN | |
| 11 BIRTHPLACE (County & State, or foreign country) MONROVIA CO MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME WM. FIELDS | | 14 MOTHER'S MAIDEN NAME Marian V. Rabbitt | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I | | 16 SOCIAL SECURITY NO 577-34-1513 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) arteriosclerosis DUE TO (c) hypertension | | INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs. 1 yr. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from 10-14, 1966 , to 12-23, 1966 , that (1) (we) last saw the deceased alive on 12-23, 1966 , and that death occurred at 8:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE R D Bauer MD | | 22b. DATE SIGNED 12-24-66 | |
| 22c. PHYSICIAN'S NAME (Type) R D Bauer MD | | 22d. ADDRESS 2513 Buckledge Rd. Wakefield, MA. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-27-66 | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. |
| 24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. RECD BY REGISTRAR DEC 29 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE L | |



17614

CERTIFICATE OF DEATH

17607

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> | | c. LENGTH OF STAY IN 1b <u>9 mo</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u> | | d. STREET ADDRESS <u>4104 Ogdenathrope St</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Jane W FLETCHER</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>17</u> Year <u>66</u> | |
| 5 SEX <u>Female</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>12-28-1878</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | 9 AGE (In years last birthday) <u>87</u> yrs. |
| 11 BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13 FATHER'S NAME <u>Thomas H. Walker</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Hughes</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO <u>215-50-6870</u> | |
| 17 INFORMANT <u>John M. Fletcher</u> | | Address <u>3502 1/2 Bangor St. B.E. Washington, D.C.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____ | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>26 March, 1966</u> , to <u>17 Dec., 1966</u> , that (I) (we) last saw the deceased alive on <u>16 Dec., 1966</u> , and that death occurred at <u>2 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Wm. A. Winters</u> | | 22b. DATE SIGNED <u>17 Dec. 1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL (CREMATION) REMOVAL (Specify) | 23b. DATE THEREOF <u>Dec. 17, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Cedar Manor Pr. Md.</u> |
| 24 FUNERAL DIRECTOR <u>Francis Pascho Sons Hapetto, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 22 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>Judge</u> |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17615

CERTIFICATE OF DEATH

17609

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | |
|---|----------------------------------|--|---|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | | c. LENGTH OF STAY IN 1b <u>4 days</u> | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suitland</u> 16.1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General Hospital</u> | | | | d. STREET ADDRESS <u>4702 Davis Avenue</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>William L. Fox</u> | | | | 4. DATE OF DEATH Month Day Year <u>December 15 19 66</u> | | | | |
| 5 SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/29/89</u> | | 9 AGE (In years last birthday) <u>77</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Adam Fox</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Katherine Winks</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address <u>Mrs. Anna Marie Bare (Dau.) Same as # 2</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Pulmonary Edema</u> DUE TO (b) <u>Severe Coronary atherosclerotic Heart Disease</u> DUE TO (c) <u>Fracture Right femur and @ humerus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> , 19 <u>66</u> , to <u>12/15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>66</u> , and that death occurred at <u>10:25 M.</u> from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE <u>A. P. [Signature]</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <u>Dec. 15-1966</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>H. E. ASUNCION, M.D.</u> | | | | 22d. ADDRESS <u>Pr. Geo's. Gen. Hospital</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec. 19-1966</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>New Hope Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Summers County, West Va.</u> | | |
| 24 FUNERAL DIRECTOR ADDRESS <u>Simmons Bros. 1661- Gd. Hope Road SE. Wash, DC</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | |

17616

CERTIFICATE OF DEATH

17610

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

| | | | | | | | |
|---|---------------------------|---|------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c. LENGTH OF STAY IN lb 36 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | | d. STREET ADDRESS 621 Sheridan St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Samuel Frichter | | | | 4. DATE OF DEATH Month Day Year December 2, 19 66 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/2/1902 | | 9. AGE (In years last birthday) 64 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Automobile | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Max Frichter | | | | 14. MOTHER'S MAIDEN NAME Anna Dyner | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-03-9586 | | 17. INFORMANT Cecelia Ginsberg Address 4711 N 11th St. Philadelphia, Pa. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> -41-1 DUE TO (b) <i>Subphrenic Abscess</i> DUE TO (c) <i>Dissecting Aortic Aneurysm & Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 weeks 3 weeks |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Coronary Arteriosclerosis</i> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 27, 19 66, to Dec. 2, 19 66, that (I) (we) last saw the deceased alive on Dec. 2, 19 66, and that death occurred at 1:20 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Saul Schwartzback</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/2/66 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Saul Schwartzback | | | | 22d. ADDRESS 1726 Eye St. Wash., D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-5-66 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Cottage City Md. | |
| 24. FUNERAL DIRECTOR <i>Charles Judge</i> | | | | 25a. REC'D BY REGISTRAR DATE DEC 7 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

17617

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17611

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil, item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 4115 71st Ave. | |
| 3. NAME OF DECEASED (Type or print) Harvey Galen Galentine | | 4. DATE OF DEATH 12 11 19 66 | |
| 5. SEX N | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 30 Oct., 1919 |
| 9. AGE (In years last birthday) 47 yrs | | 10. F UNDER 1 YEAR Months Days 11 19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY construction | |
| 11. BIRTHPLACE (State or foreign country) Greenburg Pa | | 12. CITIZEN OF WHAT COUNTRY? U S A. | |
| 13. FATHER'S NAME Homer F Galentine | | 14. MOTHER'S MAIDEN NAME Estella N Wible | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II | | 16. SOCIAL SECURITY NO. 578 12 1301 | |
| 17. INFORMANT Joyleen E Galentine | | Address Landover Hills, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease over 1 yr. (c) | | INTERVAL BETWEEN ONSET AND DEATH Minutes | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | 22. DATE SIGNED 12-11-66 | |
| EXAMINER'S NAME (Type) | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 14, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 16 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17S18

CERTIFICATE OF DEATH

17612

| | | | | | | | |
|--|--------------------------|--|-----------------------------------|--|--|--|--|
| 1. PLACE OF DEATH a COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Prince George | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale Md | | | c LENGTH OF STAY IN 1b one day | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | d STREET ADDRESS 115. Northway | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last EVA C. GARNER | | | | 4. DATE OF DEATH Month Day Year December 15th 1966 | | | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8.10.1887 | | 9 AGE (In years last birthday) 79 yrs | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S | |
| 13. FATHER'S NAME Rock | | | | 14. MOTHER'S MAIDEN NAME Winstead | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Hospital Records | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cancer of breast & metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) to bones DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec 14th, 1966, to Dec 15, 1966, that (I) (we) lost saw the deceased alive on Dec 14th 1966, and that death occurred at M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE J. A. Jefferson | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Dec. 15, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12.17.66 | | 23c NAME OF CEMETERY OR CREMATORY Bethany Baptist Cem | | 23d. LOCATION (City or Town) (County) (State) Calio Virginia | |
| 24 FUNERAL DIRECTOR Lee Funeral Home. 300.4th st N E | | | | 25a REC'D BY REGISTRAR DATE DEC 19 1966 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



17619

CERTIFICATE OF DEATH

17613

| | | | |
|---|---------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 4401 Queensbury Road | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Guy H. Gerald | | 4 DATE OF DEATH Month Day Year December 1, 1966 | |
| 5 SEX Male | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2-14-79 |
| 9 AGE (in years last birthday) yrs 87 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant | |
| 10b. KIND OF BUSINESS OR INDUSTRY U S Government | | 11 BIRTHPLACE (County & State or foreign country) Minnesota | |
| 12 CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Iver Sven Gerald | |
| 14. MOTHER'S MAIDEN NAME Marcella Strom | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | |
| 16 SOCIAL SECURITY NO 217 44 6865 | | 17. INFORMANT Medical Record/Pt. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4500 DUE TO Coronary Heart Failure (b) Deformed atherosclerosis DUE TO (c) hypertension | | INTERVAL BETWEEN ONSET AND DEATH 1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | |
| 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 18, 1966 to Dec 1, 1966 , that (I) (we) lost saw the deceased alive on Dec 1, 1966 , and that death occurred at 11:30 M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE L W Malin | | 22b. DATE SIGNED 12-1-66 | |
| 22c. PHYSICIAN'S NAME (Type) L W Malin M.D. | | 22d. ADDRESS Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF Dec 5, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 1966 | |
| 25b. REGISTRAR'S SIGNATURE W. J. Jones | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17620

CERTIFICATE OF DEATH

17614

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5702 ALICE AVENUE | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 5702 ALICE AVENUE e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) THEODORE DAVID GIBBS First Middle Last | | 4. DATE OF DEATH DECEMBER 21 19 66 Month Day Year | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1 APR 1927 9. AGE (In years last birthday) 39 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN-MSGT | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE | 11. BIRTHPLACE (County & State or foreign country) FOUNTAIN, TENN 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME WILLIAM DEWEY GIBBS (DECEASED) | | 14. MOTHER'S MAIDEN NAME ROSA COREALIA DAVIS | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES 1950-PRESENT | | 16. SOCIAL SECURITY NO 412-30-9072 | 17. INFORMANT JACQUELINE GIBBS-WIFE-SAME AS #2 Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE IMMEDIATE (c) DUE TO | | | INTERVA. BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| *21. I certify that (I) (this hospital) attended the deceased from 19 to 21 December 1966 that (I) (we) last saw the deceased alive on 19, and that death occurred at 630 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard J. Wiseley | | 22b. DATE SIGNED 21 DEC 1966 | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |
| 22c. PHYSICIAN'S NAME (Type) RICHARD J WISELEY, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12/27/66 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEMETERY | 23d. LOCATION (City or Town) (County) (State) ARLINGTON VA. |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. INC. 517 17th St. S.E. WASH. D.C. | | 25a. REC'D BY REGISTRAR DATE DEC 26 1966 | 25b. REGISTRAR'S SIGNATURE |

** SEE REVERSE SIDE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ITEM #21 CONTINUED:

MSGT THEODORE D. GIBBS, WAS BROUGHT INTO THE EMERGENCY ROOM, USAF HOSPITAL ANDREWS, ANDREWS AFB, WASHINGTON D.C. 20331, AT 6:10 P.M. HOURS, 21 DEC 1966, BY THE OXON HILL RESCUE SQUADRON AND WAS PRONOUNCED DEAD ON ARRIVAL. DR JOHN KEHOE, PRINCE GEORGE'S COUNTY MEDICAL EXAMINER WAS CONTACTED AND HE GAVE PERMISSION TO THE USAF HOSPITAL ANDREWS TO PERFORM THE AUTOPSY AND TO PREPARE THE DEATH CERTIFICATE.

17523

CERTIFICATE OF DEATH

17617

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly, Md | | c. LENGTH OF STAY IN lb Cheverly | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 6102 Lombard St | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Anna E. Gurney | | 4. DATE OF DEATH Month Day Year December 22, 1966 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 13, 1885 |
| 9. AGE (in years lost birthday) 81 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (County & State, or foreign country) Michigan | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Marvin Pickett | | 14. MOTHER'S MAIDEN NAME Lettie Foster | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO none | |
| 17. INFORMANT Margaret Gurney | | Address Cheverly, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO (b) <u>Carcinoma of Breast & metastases</u> DUE TO (c) <u>to lungs - Spine - Right Bone marrow</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-1-</u> , 19 <u>40</u> , to <u>12-22</u> , 19 <u>66</u> , that (I) (we) lost saw the deceased alive on <u>12-22</u> 19 <u>66</u> , and that death occurred at <u>10</u> M, from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>A. Deitz</u> | | 22b. DATE SIGNED Dec 22, 1966- | |
| 22c. PHYSICIAN'S NAME (Type) A. Deitz | | 22d. ADDRESS Pro Geo Plaza Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF Dec 27, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Crematory | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | 25a. REC'D BY REGISTRAR DATE DEC 27 1966 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17622

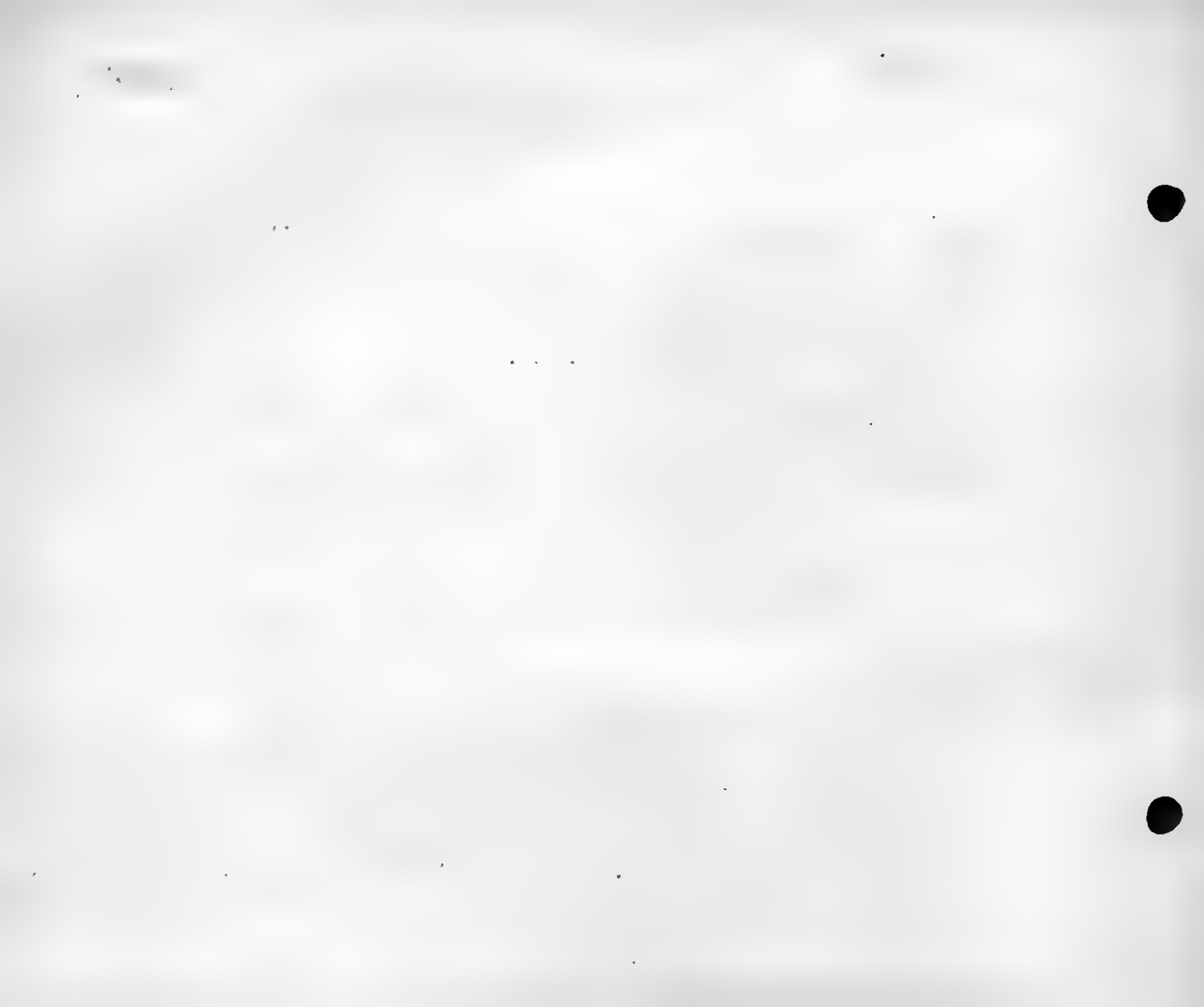
CERTIFICATE OF DEATH

17616

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If the funeral director is not the one to be retained, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--------------------------|--|---------------------------|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George | | b. STATE Maryland | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | 12 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | | | d. STREET ADDRESS 5313 76th. Ave., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Gertrude Chapman Gude | | | | 4 DATE OF DEATH Month Day Year 12 14 19 66 | | | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 1-9-16 | | 9. AGE (In years last birthday) yrs 50 | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bank clerk | | 10b. KIND OF BUSINESS OR INDUSTRY National Bank of Wash. D.C. | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles A. Gude | | | | 14. MOTHER'S MAIDEN NAME Gertrude Chapman | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown | | 16 SOCIAL SECURITY NO 577 07 0263 | | 17 INFORMANT Patient upon admission | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pleural effusion + bronchopneumonia DUE TO (b) Metastatic Ca to lung DUE TO (c) Carcinoma of breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 1 yr | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-5-66, 19 to 12-14, 1966, that (I) (we) last saw the deceased alive on 12-14-66, 19, and that death occurred at 6:10 AM, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE R. F. Wilkinson | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12-14-66 | |
| 22c. PHYSICIAN'S NAME (Type) R. F. Wilkinson, M.D. | | | | 22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF Dec. 16-1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pk. Geo. Md. | |
| 24 FUNERAL DIRECTOR F. Baschi sons of Hyattsville, Ind | | | | 25a. REC'D BY REGISTRAR DATE DEC 19 1966 | | 25b. REGISTRAR'S SIGNATURE John J. Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17621

17615

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | 2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 6833 Riverdale Rd., Apt. A-2 | |
| 3 NAME OF DECEASED (Type or print) First Ray Middle M. Last Guckert | | 4 DATE OF DEATH Month December Day 5 Year 1966 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/23/14 |
| 9. AGE (In years last birthday) 52 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer | 11. BIRTHPLACE (County & State, or foreign country) Penn. |
| 12. CITIZEN OF WHAT COUNTRY? U. S. | | 13. FATHER'S NAME unknown | |
| 14. MOTHER'S MAIDEN NAME Mary Marrow | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. 167 093150 | | 17. INFORMANT Isabel E. Guckert | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (a) Cardiac Tamponade (600 cc) DUE TO (b) Bronchogenic Carcinoma @ hilum DUE TO (c) pulmonary Emboli RLL. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 65 , to Dec 5 , 19 66 , that (I) was last saw the deceased alive on Dec 5 , 19 66 and that death occurred at 3:25 P.M. from causes on and on the date stated above. | | 22a. SIGNATURE Samuel J. N. Sugar, M.D. | |
| 22b. DATE SIGNED 12/6/66 | | 22c. PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M.D. | |
| 22d. ADDRESS 4637 Eastern Ave., Washington 18, D. C. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | |
| 23b. DATE THEREOF 12-9-66 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | |
| 23d. LOCATION (City or Town) (County) (State) Bladensburg, Md. | | 24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md. | |
| 25a. REC'D BY REGISTRAR DATE DEC 9 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT

17624

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 10, 11, 12, 13, 14 Film G384 12/22/66 mh
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17618

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 5 hrs. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Arthur Hall | | 4. DATE OF DEATH Month Day Year 12 10 66 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9. AGE (In years last birthday) 51 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | 11. BIRTHPLACE (State or foreign country) Wash., D. C. |
| 13. FATHER'S NAME George Hall | | 14. MOTHER'S MAIDEN NAME Minnie | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
| 8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO (b) Multiple skull fractures DUE TO (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause 4 101 | | | INTERVAL BETWEEN ONSET AND DEATH 5 1/2 Hrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in collision | |
| 20c. TIME OF INJURY Month, Day, Year 9:00 am 12 10 1966 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) Penna Ave at 61st Place | 20f. (City or town) (County) (State) P.G. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 12-11-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12/15/66 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. | 23d. LOCATION (City or town) (County) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR Rollins Funeral Home Inc. Hunt Rd. | | 25a. REC'D BY REGISTRAR DEC 19 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pending item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17625

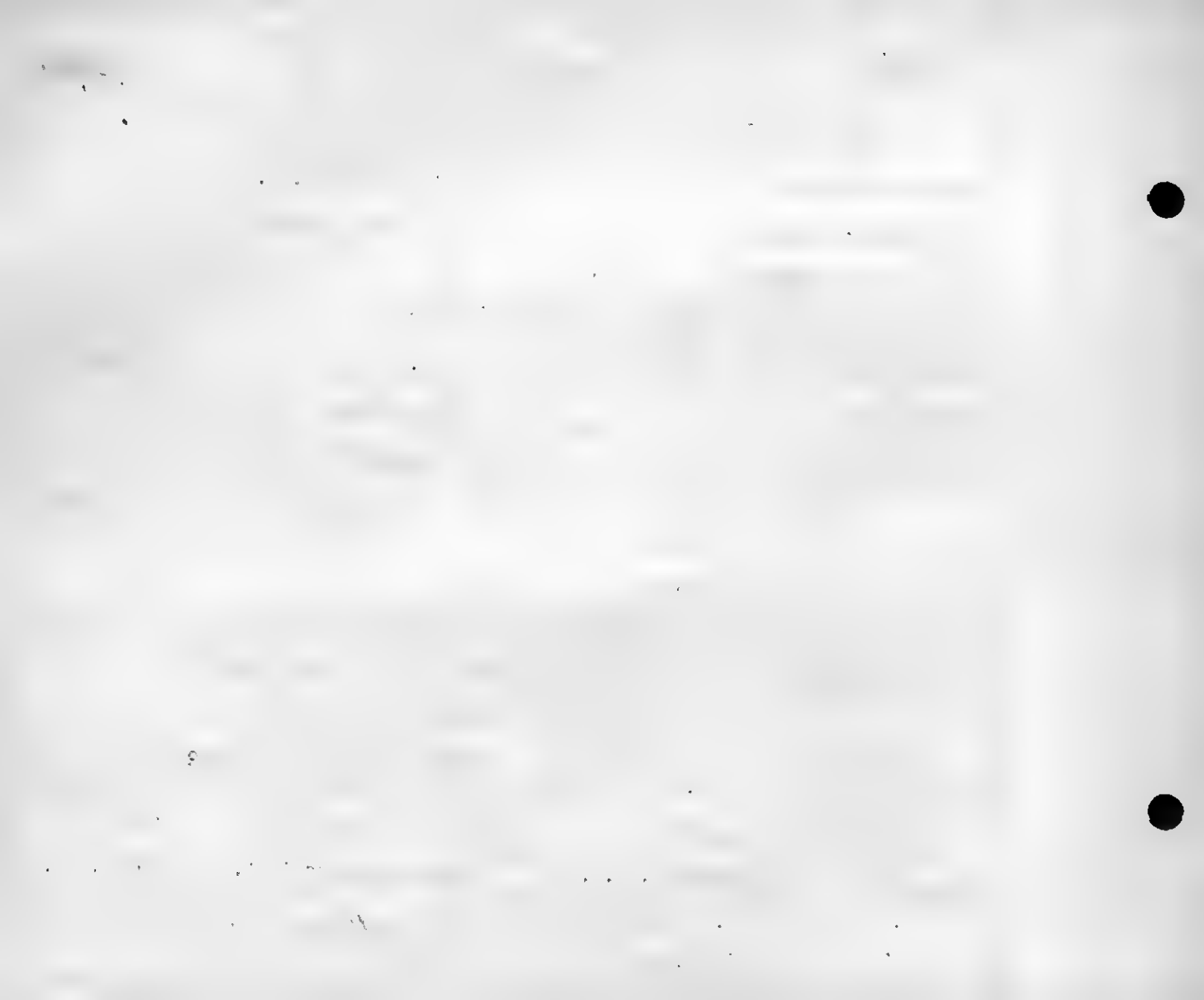
CERTIFICATE OF DEATH

17619

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE _____ b. COUNTY _____ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale Hospi | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. | |
| c. LENGTH OF STAY IN 1b 2 1/2 months | | d. STREET ADDRESS no fixed address | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Bertha Middle R. Last Hall | | 4. DATE OF DEATH Month 12/ Day 10/ Year 66 | |
| 5. SEX F | 6. COLOR OR RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/2/1895 |
| 9. AGE (In years last birthday) yrs 71 | | 10. IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired | | 10b. KIND OF BUSINESS OR INDUSTRY Ga. | |
| 11. BIRTHPLACE (County & State, or foreign country) Ga. | | 12. CITIZEN OF WHAT COUNTRY USA | |
| 13. FATHER'S NAME George Hall | | 14. MOTHER'S MAIDEN NAME Sallie Gear | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO - | |
| 17. INFORMANT decedent | | Address _____ | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebellar infarction DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 332X | | | INTERVAL BETWEEN ONSET AND DEATH unknown |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic endocarditis of aortic valve | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 9/28/ 19 66 , to 12/10/ 19 66 , that (X) (we) lost saw the deceased alive on 12/10/ 19 66 , and that death occurred at 3:10PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/10/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12-16-66 | 23c. NAME OF CEMETERY OR CREMATORY HARMONY | 23d. LOCATION (City or Town) (County) (State) HIGHLAND PARK MD. |
| 24. FUNERAL DIRECTOR ROLLINS INC. 4339 HUNT PL. N.E. WASH D.C. | | 25. REC'D BY REGISTRAR DEC 13 1966 | |
| 25a. REGISTRAR'S SIGNATURE Charles Judge | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17626

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17620

| | | | |
|--|----------------------------------|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c LENGTH OF STAY IN 1b <u>DOA</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | d STREET ADDRESS <u>3841 Church Street</u> | |
| 3 NAME OF DECEASED (Type or print) <u>Hamilton Matthias Hall</u> | | 4 DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>66</u> | |
| 5 SEX <u>Male</u> | 6 CO. OR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>15 Dec, 1900</u> |
| 9 AGE (In years as of birthday) yrs. <u>66</u> | | 10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Horse Trainer</u> | | 10b KIND OF BUSINESS OR INDUSTRY <u>Own Business</u> | |
| 11 BIRTHPLACE (State or foreign country) <u>Upper Marlboro, Md.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13 FATHER'S NAME <u>Hamilton Alexander Hall</u> | | 14 MOTHER'S MAIDEN NAME <u>Eleanor Sweeney</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u> | | 16 SOCIAL SECURITY NO <u>--</u> | |
| 17 INFORMANT <u>Marguerite Hall-Same as Item #2.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> DUE TO <u>Laceration of neck</u> (b) <u> </u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Pedestrian struck by car.</u> | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. <u>3:15pm</u> <u>12-19-19 66</u> | | 20d INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) <u>St. Rt. 4, 1/2 mile west of Upper Marlboro, Md.</u> | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> | | 22. DATE SIGNED <u>12-20-66</u> | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY | 23d LOCATION (City or Town) (County) (State) |
| <u>Burial</u> | <u>12/22/66</u> | <u>Mt. Carmel Cemetery</u> | <u>Upper Marlboro, Md.</u> |
| 24. FUNERAL DIRECTOR <u>Ritchie Bros. Upper Marlboro, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 6 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, removal, and in any event, within 72 hours after death.

17627

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17627

| | | | | | | | |
|---|----------------------------------|---|-----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 1 mo. 2 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Walter Scott Hall | | | | 4. DATE OF DEATH Month Day Year Dec 4 1966 | | | |
| 5. SEX Male | 6. COLOR OR RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-3-06 | 9. AGE (In years last birthday) 60 yrs. | 10. FINDER 1 YEAR Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Property Officer | | | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't. | | 11. BIRTHPLACE (County & State, or foreign country) Salem, W. Va. | |
| 13. FATHER'S NAME Walter Scott Hall | | | | 14. MOTHER'S MAIDEN NAME Mary Davis | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. 216-44-9746 | | 17. INFORMANT Mrs. Mary Hall, Rose Haven, North Beach, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Bronchogenic Carcinoma 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Collapsed Left lung DUE TO (c) Bilateral severe bronchopneumonia | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from June 20, 1966 , to Dec. 4, 1966 , that (I) (we) last saw the deceased alive on Dec. 4, 1966 , and that death occurred at 11:20 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles C. Hageage | | | | 22b. DATE SIGNED Dec. 4, 1966 | | 22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D. | |
| 22d. ADDRESS 3308 Perry St., Mt. Rainier, Md. | | | | 22e. REC'D BY REGISTRAR Charles Judge | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 7, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship Chr. Cemetery | | 23d. LOCATION (City, town or county) (State) Friendship, A. A. Co. Md. | |
| 24. FUNERAL DIRECTOR Butchins Funeral Home (Wings, Md.) | | | | 25. REGISTRAR'S SIGNATURE Charles Judge | | | |

FOR STATE
HEALTH DEPT.

17628

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17622

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last <u>John Aloysius Hallisey</u> | | 4 DATE OF DEATH Month Day Year <u>12 14 19 66</u> | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>31 August 1897</u> |
| 9 AGE (In years last birthday) <u>69</u> yrs | | 10 IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>D D S Professor</u> | | 10b. KIND OF BUSINESS OR <u>Georgetown University Missouri</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Missouri</u> | | 2 CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13 FATHER'S NAME <u>John M Hallisey</u> | | 14 MOTHER'S MAIDEN NAME <u>Ellen Lynch</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16 SOCIAL SECURITY NO <u>578 44 1261</u> | |
| 17. INFORMANT <u>Helen C Hallisey</u> | | Address <u>Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>And Myocardial fibrosis</u> DUE TO <u>Coronary arteriosclerotic heart disease</u> (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>over 5 yrs</u> <u>over 5 yrs.</u> <u>over 5 yrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus - over 5 years</u> | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | 22. DATE SIGNED <u>12-15-66</u> | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec 17, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland Pro Geo Md</u> |
| 24. FUNERAL DIRECTOR <u>F. Gasch, Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | |
| 25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17629

17623

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|---|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEST HYATTSVILLE</u> | | | | c. LENGTH OF STAY IN ID <u>1 1/2 YRS</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>W. HYATTSVILLE</u> | | | |
| | | | | d. STREET ADDRESS <u>1904 POWHATAN ROAD</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHNSIE</u> Middle <u>EVELYN</u> Last <u>HAMPTON</u> | | | | 4. DATE OF DEATH Month <u>DEC</u> Day <u>14</u> Year <u>1966</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>4-8-21</u> | 9. AGE (In years last birthday) <u>45</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK KEEPER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>1st NATIONAL BANK</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>ALEXANDRIA, VA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN L. LOWE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MOLLIE SUE WELLS</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>579-42-2969</u> INFORMANT <u>EVELYN WILLIAMS</u> Address <u>1904 POWHATAN RD W. HYATTSVILLE MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>HYPOTHYROIDISM</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JULY 15, 1965</u> to <u>DEC 14, 1966</u> , that (I) met last saw the deceased alive on <u>DEC 14, 1966</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Samuel J. N. Sugar</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) <u>SAMUEL J. N. SUGAR</u> | | 22d. ADDRESS <u>4637 EASTERN AVE WASHINGTON DC</u> | | | | | |
| 22b. DATE SIGNED <u>DEC 14, 1966</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>DEC. 17 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u> | 23d. LOCATION (City, town or county) (State) <u>ALEXANDRIA, VA.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>W. W. CHAMBERS CO. RIVERDALE, MD.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>DEC 19 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u> | | |

ARYLAND
17624

MEDICAL CERTIFICATION

VR A15 (4)
15M 9/60

17631

CERTIFICATE OF DEATH

17625

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE D. C. b. COUNTY 47 | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN b 9 months | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington | | d. STREET ADDRESS 610 Fairmont St., N. W. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital, Glenn Dale, Md. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First James Middle W. Last Handy | | 4. DATE OF DEATH Month 12 Day 22 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/31/01 |
| 9. AGE (In years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 22 Hours 19 Min. 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY -- | |
| 11. BIRTHPLACE (County & State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 579-16-3658 | |
| 17. INFORMANT D. C. General Hospital | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident (thrombosis rt. vertebral artery) DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| 19. INTERVAL BETWEEN ONSET AND DEATH 1 day unknown unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 3/30/ 19 66 , to 12/22/ 19 66 , that (X) (we) last saw the deceased alive on 12/22/ 19 66 , and that death occurred at 4:00 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/22/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-29-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Oliver | | 23d. LOCATION (City or town) (County) (State) Washington D.C. | |
| 24. FUNERAL DIRECTOR N.E. Adams | | 25a. REC'D BY REGISTRAR DEC 27 1966 | |
| 25b. REGISTRAR'S SIGNATURE Glenn Dale | | 26. REGISTRAR'S SIGNATURE Glenn Dale | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17532

17626

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill d. STREET ADDRESS 472 Kennebec Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Baby Boy Hardee First Middle Last 4. DATE OF DEATH December 14 1966 Month Day Year | | 5 SEX Male 6 COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8 DATE OF BIRTH 12/12/66 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years lost birthday) yrs 2 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) Prince Georges, Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Hoyt Hardee | | 14 MOTHER'S MAIDEN NAME Jacqueline Clare Burnes | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16 SOCIAL SECURITY NO. | |
| 17 INFORMANT Mother | | Address Same as above | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 764.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subdural hematoma (c) Bilateral Atelectasis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS A Topsy PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/12 , 19 66 , to 12/14 , 19 66 , that (I) (we) last saw the deceased alive on 12/14 19 66 , and that death occurred at 9:45 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Bernardo Alvarado, M.D. | | 22b. DATE SIGNED 12/17/66 | |
| 22c. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M.D. | | 22d. ADDRESS 6201 Riverdale Rd., Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF 12/24/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp. | | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland | |
| 24 FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md. | | 25a. REC'D BY REGISTRAR DEC 23 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17533

CERTIFICATE OF DEATH

17627

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, unless remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a COUNTY <u>PRINCE GEORGE</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George's</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u> | | c LENGTH OF STAY IN lb <u>21 Mos.</u> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Magnolia Gardens Nursing Home</u> | | d STREET ADDRESS <u>9104 Good Luck Rd - Maryland</u> | |
| 3 NAME OF DECEASED (Type or print) <u>MRS. BIRDIE</u> | | 4 DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1966</u> | |
| 5 SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>2/8/1880</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Alexandria, Va.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John Nolan</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16 SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Records - Nursing Home</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Carcinoma of the Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> (c) <u>?</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>—</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <u>he</u> (this hospital) attended the deceased from <u>2/22, 1965</u> to <u>2/4, 1966</u> that <u>he</u> (we) last saw the deceased alive on <u>2/4, 1966</u> and that death occurred at <u>7A</u> M, from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Wm R. Greco M.D.</u> | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>12/4/66</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Wm R. Greco M.D.</u> | | 22d. ADDRESS <u>Magnolia Gardens Nursing Home</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12/7/1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Comfort Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Fairfax County, Va.</u> |
| 24 FUNERAL DIRECTOR <u>Carroll Camen</u> | | ADDRESS <u>Alexandria, Va.</u> | 25a. REC'D BY REGISTRAR <u>DEC 8 1966</u> |
| The Demaine Funeral Homes, Inc. Va. | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

FOR STATE
HEALTH DEPT.

17634

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17628

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|---|---------------------------------|--|-------------------------------------|---|--------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bradbury Heights | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita., give street address) Prince George General Hospital | | | | d. STREET ADDRESS 5304 Pard Road | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Harry Shoemaker Harrington | | | | 4 DATE OF DEATH Month 12 Day 18 Year 1966 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 3-22-1907 | 9 AGE (In years lost birthday) yrs 59 | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS Hours Min |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b KIND OF BUSINESS OR INDUSTRY Special Police | | 11 BIRTHPLACE (State or foreign country) Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Wesley Harrington | | | | 14. MOTHER'S MAIDEN NAME Nora E. Edwards | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) Yes | | 16. SOCIAL SECURITY NO 1924-28 WWII 579-03-8582 | | 17. INFORMANT Mary E.-wife Same as #2 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 5271 IMMEDIATE CAUSE (a) Respiratory failure DUE TO Pulmonary emphysema (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | INTERVAL BETWEEN ONSET AND DEATH hours over 4 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (county) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | 22. DATE SIGNED 12-19-66 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | | | Riverdale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-22-66 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl. Cem. | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR Lee Funeral Home | | | | 25a. REC'D BY REGISTRAR DEC 27 1966 | | 25b. REGISTRAR'S SIGNATURE Charles | |
| Washington, D.C. | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17635
CERTIFICATE OF DEATH
Item 12 Film 5384-112/67 ph
17629

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <i>Prince George's</i> | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> | | c. LENGTH OF STAY IN 1b <i>2 yrs.</i> | | 2. USUAL RESIDENCE (If deceased lived, If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY <i>Washington</i> | |
| 3. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hyattsville Nursing Home 4500 Riggs Rd. Hyattsville, Md.</i> | | | | d. STREET ADDRESS <i>1315 Iris St. N.W.</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>HARRIS Carrie E.</i> | | 4. DATE OF DEATH Month <i>Dec</i> Day <i>27</i> Year <i>1966</i> | | 5. SEX <i>F</i> | | 6. COLOR OR RACE <i>Can.</i> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 8. DATE OF BIRTH <i>12/14/1877</i> | | 9. AGE (In years last birthday) <i>89 yrs.</i> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <i>Canada</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>William Harris</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Martha Mary Cunningham</i> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <i>086-26-2030</i> | | 17. INFORMANT <i>Hyattsville Nursing Home Records</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ASCD with remote cerebral vascular accident</i> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Sonility, Blindness, Spinal arthritis, Chronic urinary tract infection</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>Yrs.</i> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (a) (this hospital) attended the deceased from <i>Dec - 3</i> , 1964, to <i>Dec - 27</i> , 1966, that (b) (we) last saw the deceased alive on <i>Dec - 15</i> , 1966, and that death occurred at <i>2:12 PM</i> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Gene U. Cohen</i> M.D. (for S.T. Kinkle) | | | | 22b. DATE SIGNED <i>Dec 27, 1966</i> | | 22c. PHYSICIAN'S NAME (Type) <i>GENE U. COHEN, M.D.</i> | |
| 22d. ADDRESS <i>1106 SPRING ST SILVER SPRING, M.D.</i> | | | | 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE THEREOF <i>29 Dec. 1966</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>FOREST LAWN CEMETERY</i> | | 23d. LOCATION (City, town or county) (State) <i>BUFFALO N.Y.</i> | |
| 24. FUNERAL DIRECTOR <i>RINALDI FUNERAL HOME</i> | | 25a. REC'D BY REGISTRAR <i>DEC 20 1966</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17536
17630
CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 4304 East W. Hays e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Jerome Francis Hartnett 4. DATE OF DEATH Dec 11 1966 | | 5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 6/11/02 9. AGE (In years last birthday) 64 yrs. 10. FUNERAL 1 YEAR 11. FUNERAL 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (County & State, or foreign country) Wash. D.C. 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Joseph J. 14. MOTHER'S MAIDEN NAME MARGARET GRANEY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address LAWRENCE HARTNETT | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute Coronary Insufficiency DUE TO (b) Coronary Artery Disease DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Myocardial Infarction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 1957 to Dec 11, 1966, that (I) (we) last saw the deceased alive on Oct 1966, and that death occurred at 7:30 A.M. from the causes and on the date stated above. | |
| 22a. SIGNATURE Richard L. Whelton M.D. 22b. DATE SIGNED 12-11-66 22c. PHYSICIAN'S NAME (Type) RICHARD L. WHELTON 22d. ADDRESS 1017 University Blvd E Silver Spring Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/14/66 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven 23d. LOCATION (City, town or county) (State) Silver Spring Md. | |
| 24. FUNERAL DIRECTOR Hamilton Funeral Home 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 25c. ADDRESS 7747 Wm. Ave. 25d. DATE 12/11/66 25e. REGISTRAR'S SIGNATURE | | DEC 18 1966 | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Dr. Kelene has been notified & will approve

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|--|
| 17637 | | | | | 17631 | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville | | | c. LENGTH OF STAY IN ID 10 years | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville 16.1 | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 710 Sheridan Street | | | | | d. STREET ADDRESS 710 Sheridan Street | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) JOSEPH Luther HARTRANFT | | | 4. DATE OF DEATH 12 - 14 - 1966 | | 5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH March 24, 1890 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days Hours Min. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Machinist 11. BIRTHPLACE (County & State, or foreign country) Muncy, Pennsylvania 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | |
| 13. FATHER'S NAME Joseph W. Hartranft | | | 14. MOTHER'S MAIDEN NAME Elmira Rogers | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 16. SOCIAL SECURITY NO. 220-44-0896 17. INFORMANT Janet B. Hartranft Address: 710 Sheridan Street Hyattsville, Md. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion (b) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/18, 1966, to 12/14, 1966, that (I) (we) last saw the deceased alive on 10/18, 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE R. C. Kirchner | | | | | 22b. DATE SIGNED 12-14-66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) R. C. KIRCHNER | | | | | 22d. ADDRESS 6480-N.H. AVE - TAKOMA PARK MD | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Dec. 17, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City, town or county) (State) Prince Georges Co., Md. | | |
| 24. FUNERAL DIRECTOR C. Glen Carter 8434 Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md. | | | | | 25a. REC'D BY REGISTRAR DEC 20 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

CERTIFICATE OF DEATH

17638

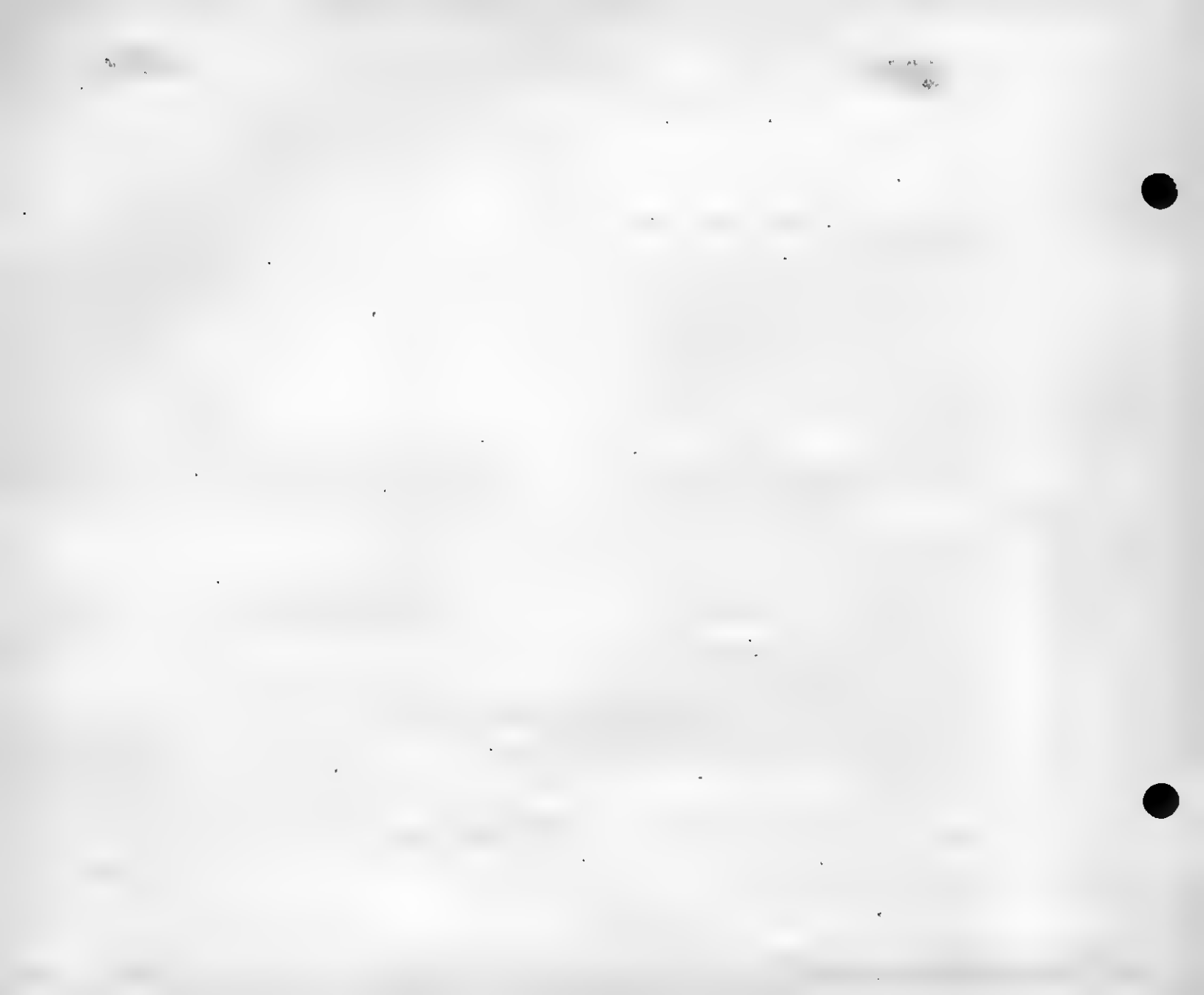
17632

| | | | | | |
|--|------------------------------|---|------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Md. b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANTHAM, MD. | | c. LENGTH OF STAY IN ID | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNIVERSITY PARK | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAGNOLIA GARDENS NURSING HOME | | | | d. STREET ADDRESS 4009 TENNYSON RD. | |
| 3. NAME OF DECEASED (Type or print) | | First Middle Last MARGARET HEINEMAN | | 4. DATE OF DEATH Month Day Year DEC. 21 1966 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/30/83 | 9. AGE (In years last birthday) yrs 83 | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min. |
| 10a. US ARMY OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Baltimore | |
| 13. FATHER'S NAME Dietrich Haesloop | | 14. MOTHER'S MAIDEN NAME Julia Schmidt | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. --- | | 17. INSURANCE Address Son 718 Murdoch Rd | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - orthopneustic 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) Generalized arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes mellitus | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to Dec. 21, 1966 that (I) (we) last saw the deceased alive on Dec 20 1966 and that death occurred at 2:34 AM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Don B. Cameron M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22c. PHYSICIAN'S NAME (Type) DON B. CAMERON | | | | 22b. DATE SIGNED DEC 21, 1966 | |
| 22d. ADDRESS 3503 PERRY ST MOUNT RAINIER, MD | | | | | |
| 23a. BURIAL, CREMATORY, REMOVAL Specify | | 23b. DATE THEREOF Dec. 23, 66 | | 23c. NAME OF CEMETERY OR CREMATORY Balto | |
| 23d. LOCATION (City or town) Balto Md | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR H. Heumann | | ADDRESS 6067 Hayford Rd | | 25a. REC'D BY REGISTRAR DATE DEC 30 1966 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | |

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VR A15 (4)
20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17639

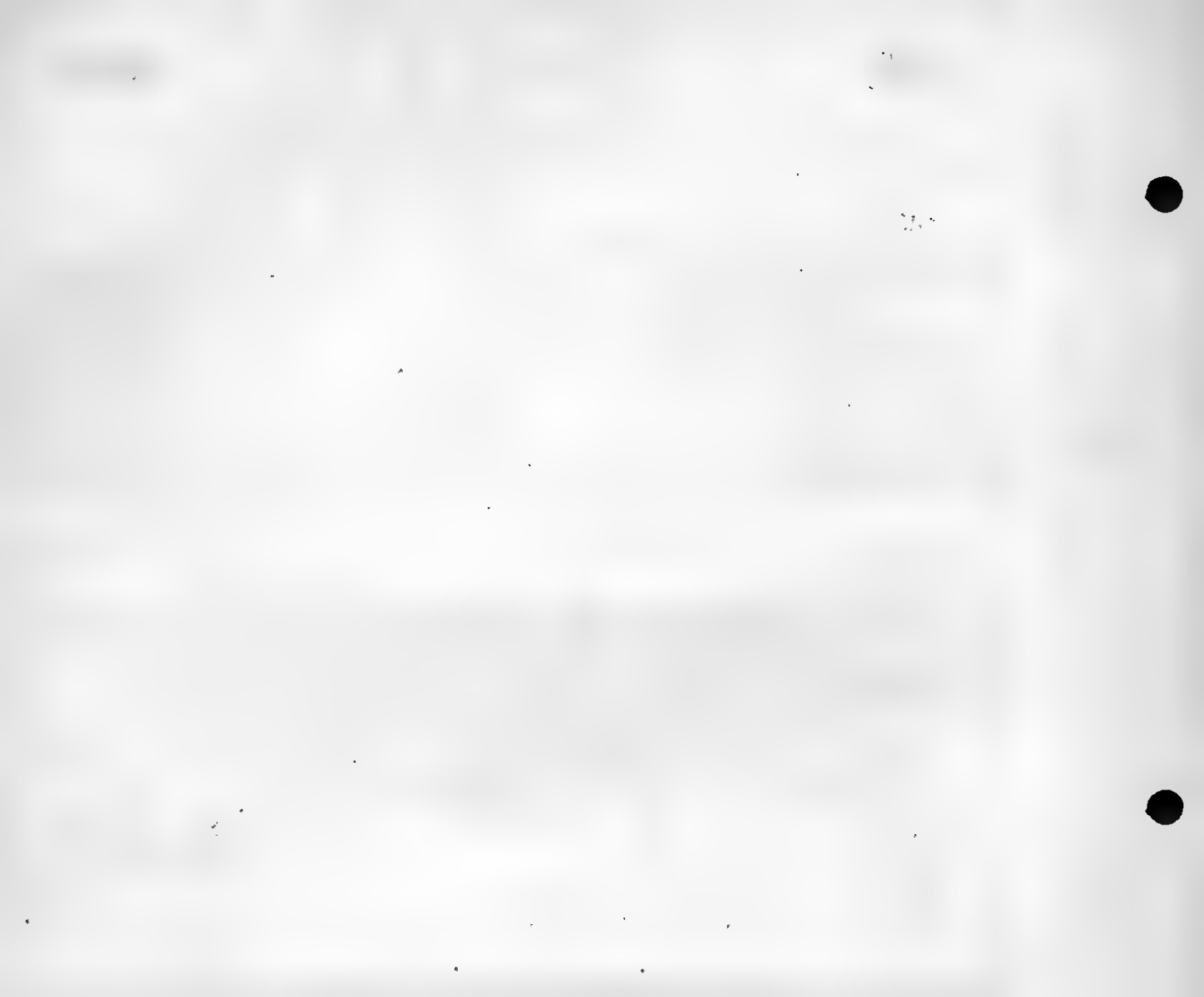
CERTIFICATE OF DEATH

17633

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE MARYLAND b. COUNTY Charles County | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY IN (b) 14 DAYS | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA | |
| f. STREET ADDRESS 62 HAWTHORNE DRIVE | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ROSAMOND ADELAIDE HELWIG | | 4. DATE OF DEATH Month Day Year DECEMBER 20 1966 | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12 DEC 1917 |
| 9. AGE (In years last birthday) 49 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER | | 10b. KIND OF BUSINESS OR INDUSTRY SCHOOL TEACHER | |
| 11. BIRTHPLACE (County & State, or foreign country) GREENVILLE, N.C. | | 12. CITIZENSHIP OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ZACK VAN DYKE | | 14. MOTHER'S MAIDEN NAME ADELAIDE TAFT | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO N/A | | 16. SOCIAL SECURITY NO. 242-42-2114 | |
| 17. INFORMANT EDWARD W HELWIG-HUSBAND-SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X WIDESPREAD METASTATIC BREAST CANCER DUE TO (b) CARCINOMA OF BREAST DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 1 YEAR 1 YEAR |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS A JIOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that XX (this hospital) attended the deceased from 5 DEC, 1966, to 20 DEC, 1966, that (X) (we) last saw the deceased alive on 20 DEC 1966, and that death occurred at 10:55 A.M., from causes and on the date stated above | | | |
| 22a. SIGNATURE Charles D Phelps | | 22b. DATE SIGNED 10:55 A.M. 20 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) CHARLES D PHELPS, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 23, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Va. |
| 24. FUNERAL DIRECTOR Arehart Funeral Home Inc., La Plata, Md. | | 25a. REC'D BY REGISTRAR DEC 30 1966 25b. REGISTRAR'S SIGNATURE Charles D Phelps | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



17640

CERTIFICATE OF DEATH

17634

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB c. LENGTH OF STAY IN 1b 4HR 15MIN d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMP SPRINGS d. STREET ADDRESS 5565 MAXWELL DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) JANE CANODY HILBISH | | | | 4. DATE OF DEATH Month 12 Day 19 Year 66 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAUCASIAN | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3 JUNE 1922 | |
| 9. AGE (In years lost birthday) 44 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICER | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. AIR FORCE | | 11. BIRTHPLACE (County & State, or foreign country) WOODSON, AMHURST, VA. | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 13. FATHER'S NAME GEORGE FREDERICK HILBISH | | | |
| 14. MOTHER'S MAIDEN NAME ADA LEE CANODY | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1957-PRESENT | | | |
| 16. SOCIAL SECURITY NO 230-28-0667 | | 17. INFORMANT OFFICIAL U.S. AIR FORCE RECORDS Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumococcal Meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumococcal Septicemia DUE TO (c) | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myelofibrosis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that NO (this hospital) attended the deceased from 12 DEC , 19 66 , to 12 DEC , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12 DEC , 19 66 , and that death occurred at 11:25 P.M. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Walter Myalis | | | | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 12 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) WALTER A MYALIS, CAPT, USAF, MC | | | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | | | |
| 23a. BURIAL CREMATION REMOVE (Specify) 12/14/66 | | 23b. DATE THROFF | | 23c. NAME OF CEMETERY OR CREMATORY AMHERST | | 23d. LOCATION (City or Town) (County) (State) AMHERST VA | |
| 24. FUNERAL DIRECTOR Wm. Chambers Co. 5141 51st St. S.E. | | | | 25a. REC'D BY REGISTRAR DATE DEC 19 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1764i

CERTIFICATE OF DEATH

17635

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c. LENGTH OF STAY IN 1b Washington, D. C. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Washington, D.C. b. COUNTY Washington, D. C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C. d. STREET ADDRESS 3211 Nichols Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Carl Edward Himmler | | 4. DATE OF DEATH Month Day Year 12-28-66 19 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-8-06 |
| 9. AGE (In years last birthday) yrs 60 | | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER | | 10b. KIND OF BUSINESS OR INDUSTRY CONTRACTING | |
| 11 BIRTHPLACE (County & State, or foreign country) W. Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samples | | 14. MOTHER'S MAIDEN NAME UNK | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO 578-2463 | |
| 17. INFORMANT Medical Records/ Anne Armentrout, daughter. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Htg Disease DUE TO (c) Arteriosclerosis Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 3-5 yrs 5-10 yrs | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus 3 yrs & gangrene of Rt foot 6 mo | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I and Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-6- , 19 66 , to 12-28 , 19 66 that (I) (we) last saw the deceased alive on 12-27- 19 66 , and that death occurred at 4:30 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Walcutt G. Gibson | | 22b. DATE SIGNED 12-28-66 | |
| 22c. PHYSICIAN'S NAME (Type) Walcutt Gibson, M.D. | | 22d. ADDRESS 4340 St. Barnabas Rd., Marlow Heights, Md. 20031 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/31/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY WASH. NAT'L | | 23d. LOCATION (City or Town) (County) (State) P.R. Geo. Co. MD | |
| 24. FUNERAL DIRECTOR W.C. Charles Co. Inc 5121 N. St. | | 25a. REC'D BY REGISTRAR DEC 30 1966 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

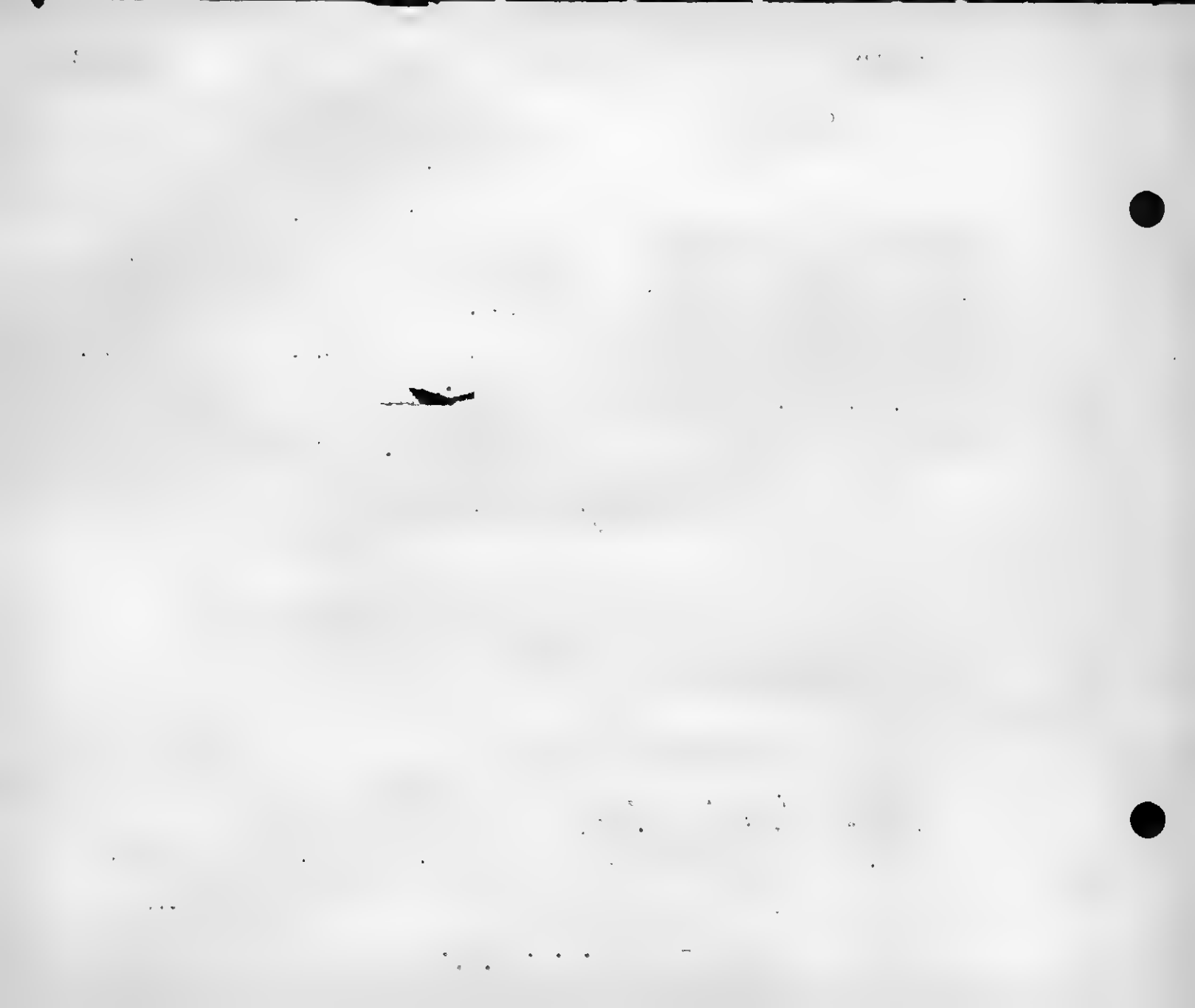
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|-----------------------------------|--|---|--|-----------------------------------|---|---|------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 17642 | | | | | 17636 | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| Prince George General Hospital | | | 7204 Wells Blvd. | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | 4. DATE OF DEATH | | 5. AGE (In years last birthday) | | | | | | |
| CHARLES LEWIS HOLTHAUS | | | December 27, 1966 | | 61 yrs. | | | | | | |
| 5. SEX Male | | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Feb. 13, 1905 | | 9. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) | | | 12. CITIZEN OF WHAT COUNTRY? | | | |
| Contractor | | | | | Washington, D.C. | | | U.S.A. | | | |
| 13. FATHER'S NAME Charles L. Holthaus | | | | | 14. MOTHER'S MAIDEN NAME Tower Charlotte Tower | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Margaret G. Holthaus-wife same 2d | | | | | | |
| No | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 11/64, 19, to 12/27, 1966 that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above. | | | | 22a. SIGNATURE Dr. W. Wainwright 22c. PHYSICIAN'S NAME (Type) Charles H. Wainwright 22d. ADDRESS 9 EE Chase St., Baltimore, Md. | | | | | | 22b. DATE SIGNED | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE THEREOF Dec. 30, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 23d. LOCATION (City, town or county) (State) Washington D.C. | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C. | | | | 25a. REC'D BY REGISTRAR DEC 30 1966 | | 25b. REGISTRAR'S SIGNATURE | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

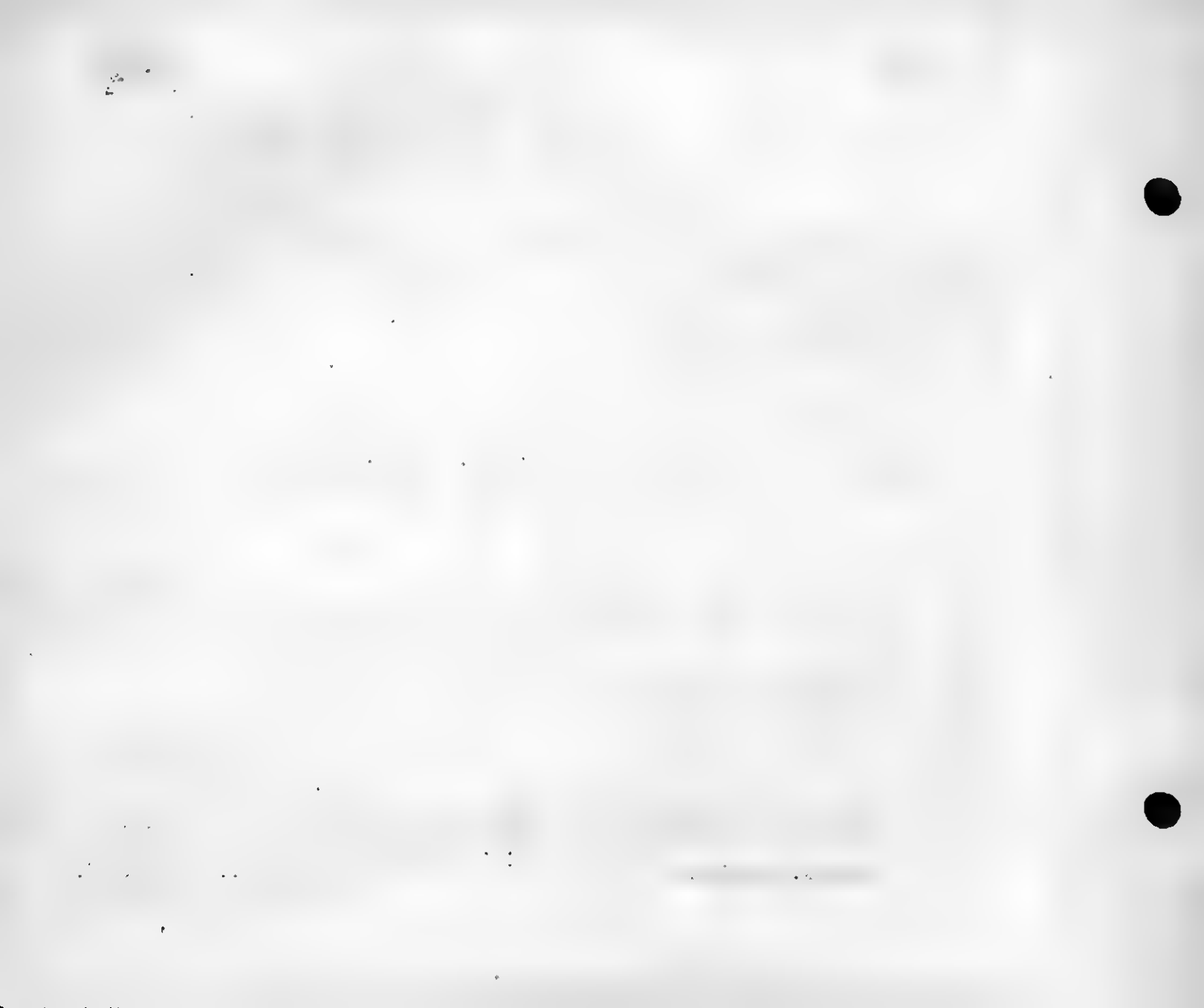
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17643

CERTIFICATE OF DEATH

17637

| | | | |
|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Lanham Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | e. STREET ADDRESS 7504 Dover Lane | |
| 3 NAME OF DECEASED (Type or print) First John Middle F Last Horrigan | | 4. DATE OF DEATH Month Dec. Day 5 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 15 Nov., 1899 |
| 9. AGE (In years last birthday) 67 yrs | | 10. CITIZEN OF WHAT COUNTRY? USA | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Funeral Director | |
| 11. BIRTHPLACE (County & State or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Horrigan | | 14. MOTHER'S MAIDEN NAME Mary Cunningham | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT May E. Horrigan | | Address 7504 Dover Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 162.1 IMMEDIATE CAUSE (a) acute leukemia DUE TO (b) leukopenia DUE TO (c) myelogenous leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 , 19 12-5 , 19 65 , that (I) (we) last saw the deceased alive on 12-5-65 , and that death occurred at 11:45 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE James W. Harding | | 22b. DATE SIGNED 12/6/66 | |
| 22c. PHYSICIAN NAME (Type) James W. Harding | | 22d. ADDRESS 7601 Riverdale Rd., Lanham, Md. | |
| 23a. 8 BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12/9/66 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Prince Georges, Maryland |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home | | 25a. REC'D BY REGISTRAR DATE DEC 9 1966 | |
| 4308 Suitland Road, Suitland Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17644

CERTIFICATE OF DEATH

17638

| | | | | | |
|---|--------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham | | c. LENGTH OF STAY IN TB | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Magnolia Gardens Nursing Home | | | | d. STREET ADDRESS 3917 Commander Drive | |
| 3. NAME OF DECEASED (Type or print) First Middle Last LYDIA MATILDA HOUSER | | 4. DATE OF DEATH Month Day Year Dec. 10, 1966 | | | |
| 5. SEX Female | 6. CO. OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 12, 1879 | | 9. AGE (In years last birthday) yrs 87 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work month, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | | 11. BIRTHPLACE (County & State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Christian Metzger | | | 14. MOTHER'S MAIDEN NAME Pricilla Zettlemoyer | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213 56 2465 | | 17. INFORMANT Phyllis M. Lovell Same as #2 (daughter) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac Myocardial Failure 334X DUE TO Cerebral Arterio-sclerosis, old, & Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) Generalized Hemiplegia DUE TO (c) Arterio-sclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1959 , 19 66 , to 1966 , that (I) (we) last saw the deceased alive on 12/17/66 19 66 , and that death occurred at 1:15 M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE Walcott Etienne | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/10/66 | |
| 22c. PHYSICIAN'S NAME (Type) Walcott Etienne, M.D. | | 22d. ADDRESS Berwyn Road College Park, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 13, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery | |
| 23d. LOCATION (City or Town) Colman Manor Pk. Hyattsville Md | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR F. Buschi sons Hyattsville Md | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE DEC 15 1966 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17645

CERTIFICATE OF DEATH

17639

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial; and in any event, within 72 hours after death.

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pro Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6208 57th avenue | | d. STREET ADDRESS 6208 57th avenue | |
| 3 NAME OF DECEASED (Type or print) First John M. Middle Hutchens Last sr | | 4 DATE OF DEATH Month Dec 13, 1966 Day 19 Year 19 | |
| 5. SEX male | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH April 15, 1902 |
| 9 AGE (In years last birthday) yrs. 64 | | 10 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad cars | |
| 11 BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Keyton Hutchens | | 14. MOTHER'S MAIDEN NAME Rose Shea | |
| 15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give wpr or dates of service) yes | | 16. SOCIAL SECURITY NO W W 1 | |
| 17. INFORMANT Evelyn R Mc Kenzie | | Address Adelphi, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Emphysema</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 19</u> , 19 <u>68</u> to <u>12/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>66</u> , and that death occurred at <u>8 AM</u> , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Chas. V. Paye</u> | | 22b. DATE SIGNED <u>12/13/66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>CHAS. V. PAYE MD.</u> | | 22d. ADDRESS <u>7520 Riverdale Rd Hyattsville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 16, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | 25a. REC'D BY REGISTRAR DATE DEC 19 1966 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE <u>J. J. J.</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 6 Film 3-83 12/12/66 mh

CERTIFICATE OF DEATH

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE b. COUNTY Washington, D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nussing Home | | d. STREET ADDRESS 2708 30th Street S.E. | |
| 3. NAME OF DECEASED (Type or print) PAUL JOHNSON | | 4. DATE OF DEATH Dec 5th 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb 2nd 1881 |
| 9. AGE (In years lost birthday) 85 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 11. BIRTHPLACE (County & State, or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Johnson | | 14. MOTHER'S MAIDEN NAME Mary Ellen Kelliher | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes 1900-1904 | | 16. SOCIAL SECURITY NO 578-66-8813 | |
| 17. INFORMANT Address Florence M. Johnson Same as # 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 DUE TO (b) Cyanosis & Dehydration (c) Cyanosis of both feet Generalized Arteriosclerosis 10 yr | | INTERVAL BETWEEN ONSET AND DEATH 2 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Brain Syndrome due to ASCWA | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 21. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 24. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11/21/1966 to 12/5/1966 that (I) (we) last saw the deceased alive on 12/4 1966 and that death occurred at 1:05 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Kelvin L. Minchin M.D. | | 22b. DATE SIGNED 12/5/66 | |
| 22c. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN | | 22d. ADDRESS 6400 MARLBORO PINE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-9-1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l | 23d. LOCATION (City or Town) (County) (State) Fort Myer, Va |
| 24. FUNERAL DIRECTOR Peter D. Mattingly | | 25. REC'D BY REGISTRAR 131-11788 DATE DEC 7 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17647

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17641

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|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a STATE b COUNTY Maryland Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b DOA | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Roy Chancellor Jones | | 4 DATE OF DEATH Month Day Year 12 16 19 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH 6 March 1880 |
| 9 AGE (In years last birthday) 86 yrs | | 10 UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b KIND OF BUSINESS OR INDUSTRY Building | |
| 11 BIRTHPLACE (State or foreign country) Virginia | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME James T. Jones | | 14 MOTHER'S MAIDEN NAME Susan J. Grimsley | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1901 - 1905 | | 16 SOCIAL SECURITY NO 579 03 5935 | |
| 17 INFORMANT Anne L. Jones Same as #2 (neice) | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, I.D. | | 22. DATE SIGNED 12-16-66 | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12/20/66 | 23c NAME OF CEMETERY OR CREMATORY Arlington National |
| 24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md. | | 23d LOCATION (City or Town) (County) (State) Arlington, Arlington Va. | 25a REC'D BY REG STRAR DATE DEC 22 1966 |
| | | 25b REG STRAR'S SIGNATURE Charles Judge | |

[illegible]

4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 8

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CERTIFICATE OF DEATH

Reg. Dist. No.

17642

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges County MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5012 Hollywood Road | | d. STREET ADDRESS 5012 Hollywood Road | |
| 3. NAME OF DECEASED (Type or print) NOVELIA O'REILLY KEIM | | 4. DATE OF DEATH Month 12 Day 20 Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 8, 1891 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner | | 10b. KIND OF BUSINESS OR INDUSTRY Religious Articles St. Louis, Missouri | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Thomas G. O'Reilly | | 14. MOTHER'S MAIDEN NAME Charlotte Schemmel | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No | | 16. SOCIAL SECURITY NO. Unknown | |
| 17. INFORMANT Marguerite O'Reilly Reitz, Rd. College Pk. | | Address 5012 Hollywood Rd. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Carcinoma of Colon with Metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 6 mo. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Dec 8 , 1966, to Dec 20 , 1966, that I last saw the deceased alive on Dec 12, 1966 , and that death occurred at 11:30 M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L W Malone M.D. | | ADDRESS (Street, city or town, state) Riverdale, Md. DATE SIGNED 12-12-66 | |
| PHYSICIAN'S NAME (Type) L W Malone M.D. | | Riverdale, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Dec. 23, 1966 | 22c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | 22d. LOCATION (City, town, or county) (State) East McKeesport, Pennsylvania |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., Riverdale, Md. | | 24a. REC'D BY REGISTRAR DATE 27 1966 | 24b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

| | | | |
|---|---------------------------|--|-------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Buffalo | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | e. STREET ADDRESS c/o Bellare Department 577 Ellicott Street | |
| 3. NAME OF DECEASED (Type or print) Charles S Kendrick | | 4. DATE OF DEATH 12 7 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-19-1909 |
| 9. AGE (in years last birthday) 57 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | |
| 11. BIRTHPLACE (State or foreign country) Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John James Kendrick | | 14. MOTHER'S MAIDEN NAME Blanche Roberson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 577-28-4478 | |
| 17. INFORMANT John Kendrick | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema, bilateral, severe 522X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (Etiology undetermined) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | |
| 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20d. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 12-9-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL OR CREMATION Burial | | 23b. DATE THEREOF 12-12-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City, town or county) (State) Suitland, Md | |
| 24. FUNERAL DIRECTOR R. H. Matthews | | 25a. REC'D BY REGISTRAR DEC 5 1966 | |
| ADDRESS 131-11 St. & Wash 300 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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17650

CERTIFICATE OF DEATH

17644

| | | | |
|---|--------------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 3 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 4301 Oglethorpe Street | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Ada C Kidwell | | 4 DATE OF DEATH Month Day Year Dec. 23 19 66 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 27 Sept., 1879 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11 BIRTHPLACE (County & State or foreign country) Berkley Springs, W. Va. | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert A. Heitt | | 14. MOTHER'S MAIDEN NAME Sarah Powell | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO. 213-18-2170 | |
| 17. INFORMANT Mr. Melvin A. Kidwell (son) | | Address (above address) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4330 DUE TO Cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced arteriosclerosis of the coronary vessels DUE TO (c) dissection | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 66 , to 12-23 , 19 66 , that (I) (we) last saw the deceased alive on 12-22 , 19 66 , and that death occurred at 3:45 AM from causes on and on the date stated above. | | | |
| 22a. SIGNATURE John R. Lilly | | 22b. DATE SIGNED 12-23-66 | |
| 22c. PHYSICIAN'S NAME (Type) John R. Lilly, M.D. | | 22d. ADDRESS 4410 74th Ave., Bellemead, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/27/66 | 23c. NAME OF CEMETERY OR CREMATORY Burtonsville Cem. | 23d. LOCATION (City or town) (County) (State) Burtonsville, Md. |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | ADDRESS Lt. Rainier Maryland | 25a. REC'D BY REGISTRAR DEC 23 1966 |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

17651

17645

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Warner Kirk</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>18</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>30 Nov., 1921</u> |
| 9. AGE (In years last birthday) <u>45</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FOREMAN</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>ROBERT E. KIRK</u> | | 14. MOTHER'S MAIDEN NAME <u>ALICE MYERS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>577189414</u> | |
| 17. INFORMANT <u>NATALIE B. KIRK</u> | | Address <u>SAME AS #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>over 5 yrs.</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D., Riverdale</u> | | 22. DATE SIGNED <u>12-18-66</u> | |
| 23a. BURIAL, CREMATION, REMOVA (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>12-21-1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM</u> | 23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u> |
| 24. FUNERAL DIRECTOR <u>W. W. Chambers Co Riverdale, Md.</u> | | 25a. REC'D BY REGISTRAR <u>DEC 27 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17652

CERTIFICATE OF DEATH

Reg. Dist. No.

17646

| | | | | | |
|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George County</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlow Heights</u> | | c. LENGTH OF STAY IN 1b <u>8 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlow Heights</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4830 Oxford Drive</u> | | | d. STREET ADDRESS <u>4850 Oxford Drive</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>MALCOLM</u> Middle <u>A</u> Last <u>KLINE</u> | | | 4. DATE OF DEATH Month <u>December</u> Day <u>2</u> Year <u>1966</u> | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/28/1907</u> | | 9. AGE (In years last birthday) <u>59</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bricklayer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>construction</u> | | 11. BIRTHPLACE (State or foreign country) <u>Palmerton, Pa.</u> | |
| 13. FATHER'S NAME <u>AUGUST KLINE</u> | | | 14. MOTHER'S MAIDEN NAME <u>EMMA LIEBENGUTH</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>179-05-504</u> | | 17. INFORMANT <u>EMMA ROBERTS</u> Address <u>See #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>PULMONARY EDEMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HYPERTENSIVE HEART DISEASE</u> (c) <u>12 DAYS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CIRRHOSIS OF LIVER</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 DAYS</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that I attended the deceased from <u>5/11</u> , 19 <u>65</u> , to <u>12/2</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>12/2/66</u> , 19 <u>66</u> , and that death occurred at <u>4 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4400 Stamp Road, Temple Hills, Md.</u> DATE SIGNED <u>12/7/66</u> | | | | | |
| ACTUAL SIGNATURE <u>Bruno Kolega</u> M.D. | | PHYSICIAN'S NAME (Type) <u>BRUNO KOLEGA, M.D.</u> <u>4400 Stamp Road, Temple Hills, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u> | 22b. DATE THEREOF <u>12/2/66</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>INDIAN LAND</u> | 22d. LOCATION (City, town, or county) | (State) <u>Cherryville, PENNA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.</u> | | ADDRESS <u>5711 17th St. S.E.</u> <u>Wash. D.C.</u> | | 24a. REC'D BY REGISTRAR DATE <u>DEC 3 1966</u> | 24b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 17653 | | | | | | 17647 | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7304 Riverdale Road | | | | | | d. STREET ADDRESS 7304 Riverdale Road | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Carolyn Gress Knapp | | | | | | 4. DATE OF DEATH Month Day Year 12 6 1966 | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE Cauc. | | 7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-15-80 | | 9. AGE (In years last birthday) 86 yrs. | | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Homemaker | | | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Samuel Gress | | | | | | 14. MOTHER'S MAIDEN NAME Phoebe Wickizer | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. No | | 17. INFORMANT Address Mrs. Dewey T Jones - Same as #2d | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory failure 420.0 BUE TO (b) Interostatic heart disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ca of breast INTERVAL BETWEEN ONSET AND DEATH first hours year year | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1952 to 12/6, 1966, that (I) (we) last saw the deceased alive on 9/17 1966, and that death occurred at 10:30 AM, from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE James Kurz | | | | | | 22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) A. James Kurz | | | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | | | 23b. DATE THEREOF 12-6-66 | | 23c. NAME OF CEMETERY OR CREMATORY Lee Crematory | | 23d. LOCATION (City, town or county) (State) Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home, 3004th St, NE, Wash, DC | | | | | | 25a. REC'D BY REGISTRAR DATE DEC 9 1966 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | |

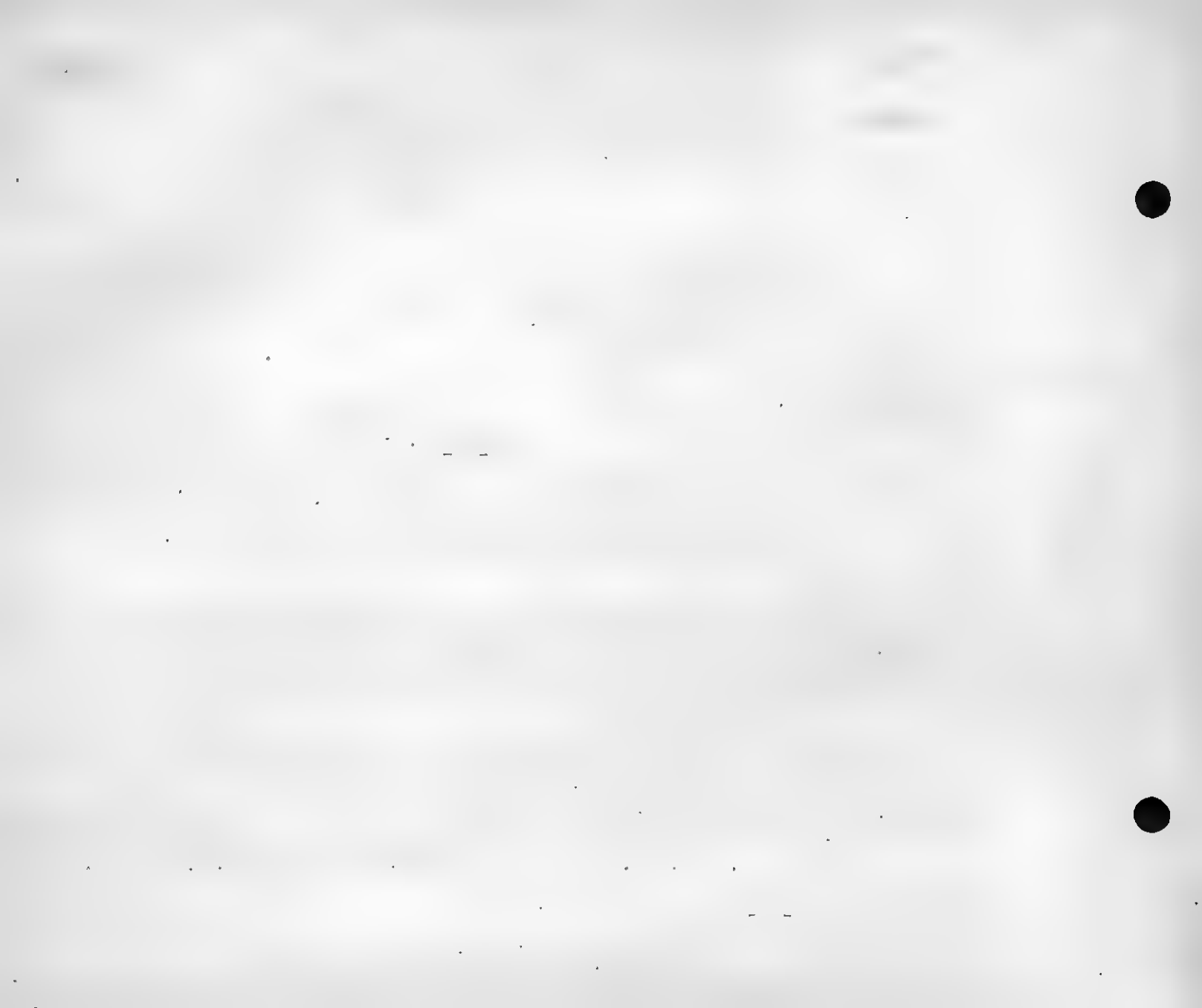
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|--|
| 17654 | | | | | 17648 | | | | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b 8 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) USAF HOSPITAL ANDREWS | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OXON HILL d. STREET ADDRESS 5507 BARI DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print) GRACE TAYLOR KOON | | | | | 4. DATE OF DEATH 28 DECEMBER 1966 | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE CAU | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8 APRIL 1891 | | 9. AGE (In years last birthday) 75 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (County & State, or foreign country) PHILADELPHIA, PA. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME CHARLES AUGUSTUS FEATHER | | | | | 14. MOTHER'S MAIDEN NAME ISABELL ADAIR | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) N/A | | 17. INFORMANT RAYMOND G. BOURASSA SON-IN-LAW | | | Address SAME AS # 2 | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory + cardiac failure DUE TO (b) Generalized arteriosclerosis, severe DUE TO (c) Complete heart block, chronic cholecystitis & cholecystostomy CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 4 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 20 Dec 1966 to 28 Dec 1966 , that (I) OWN last saw the deceased alive on 27 Dec 1966 , and that death occurred at 0930 AM , from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Philip A. Cox, Col. | | | | | 22b. DATE SIGNED 28 Dec 66 | | | | |
| 22c. PHYSICIAN'S NAME (Type) PHILIP A. COX, COL, USAF, MC | | | | | 22d. ADDRESS ANDREWS AFB USAF HOSPITAL ANDREWS, WASH, D.C. 20331 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-31-66 | | 23c. NAME OF CEMETERY OR CREMATORY New Camden Cemetery | | 23d. LOCATION (City, town or county) (State) Camden New Jersey | | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd Suitland Maryland | | | | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | | | | |
| | | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

MEDICAL CERTIFICATION

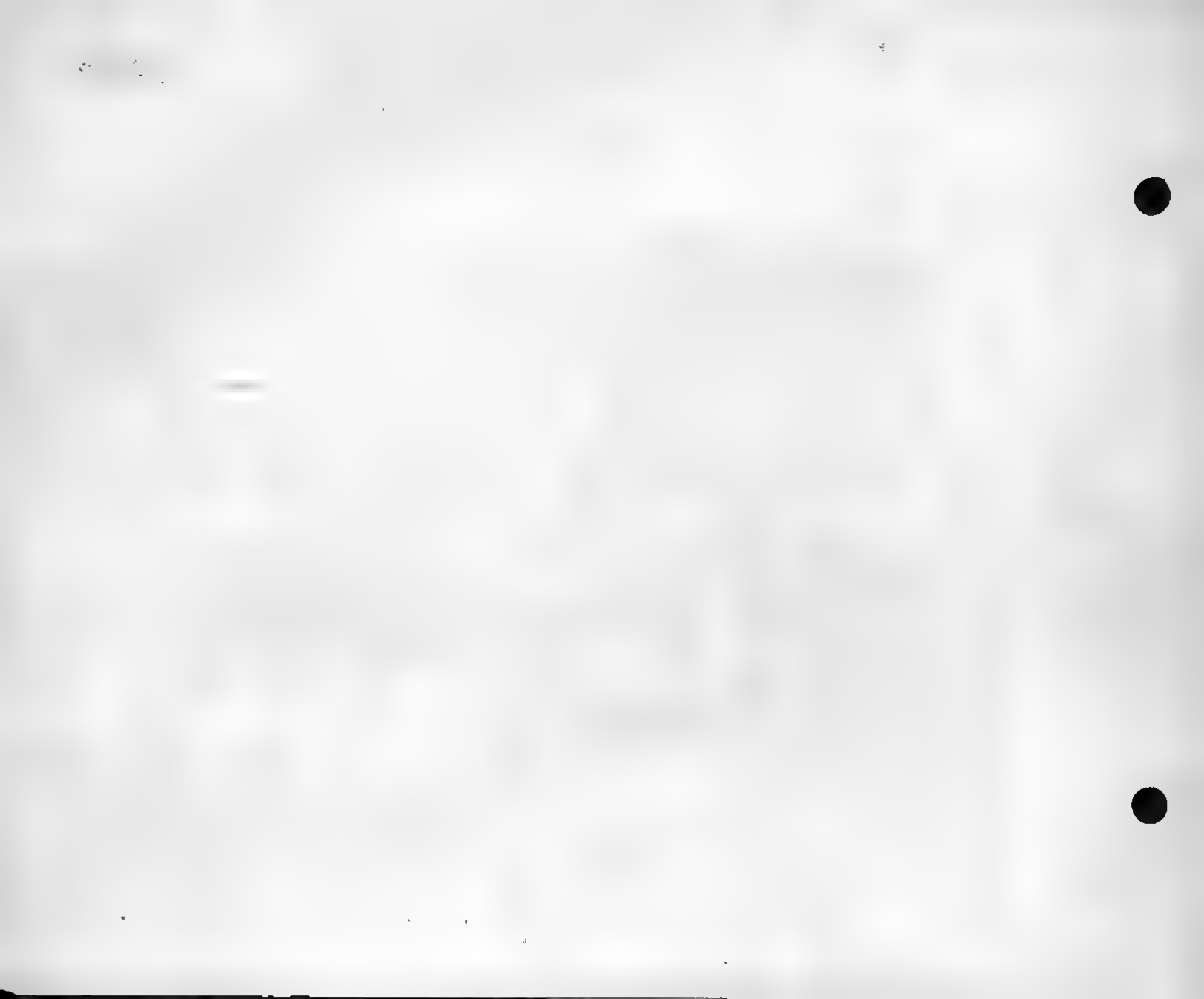


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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| 178555 CERTIFICATE OF DEATH 17649 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S COUNTY</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | | c. LENGTH OF STAY IN 1b <u>17 YEARS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md.</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5902 15TH AVE., Hyattsville, Md.</u> | | | | | d. STREET ADDRESS <u>5902 15TH AVE., Hyattsville Md</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>D.</u> Last <u>LANKFORD</u> | | | | | 4. DATE OF DEATH Month <u>December</u> Day <u>25</u> Year <u>1966</u> | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>April 25, 1895</u> | | 9. AGE (In years last birthday) <u>71</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISABILITY (VETERAN)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | |
| 13. FATHER'S NAME <u>UNKNOWN</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>MARTHA ANN O'NEIL</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>220-50-9054</u> | | 17. INFORMANT <u>RUSSELL E. REID</u> | | | Address <u>5902 15TH AVE., Hyattsville Md</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Pulmonary Emphysema</u> <u>Smoking</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CHRONIC BRONCHITIS</u> DUE TO (c) <u>SMOKING</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>25 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 <u>66</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | | 20f. (City or town) (County) (State) _____ | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>59</u> , to <u>December</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>December 20</u> 19 <u>66</u> , and that death occurred at <u>11:20</u> PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Hugo G. Graziani</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>12/26/66</u> | | |
| 22c. PHYSICIAN'S NAME (Type) <u>HUGO G. GRAZIANI, M.D.</u> | | | | | 22d. ADDRESS <u>11512 STEWART LANE, B2, SILVER SP., MD.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/29/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Com.</u> | | 23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | | | ADDRESS <u>Lt. Rainier Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JAN 3 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17656

CERTIFICATE OF DEATH

17650

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|---------------------------------|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND | | c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1907 GAYLORD DRIVE S. E. | | | | d. STREET ADDRESS 1907 GAYLORD DRIVE S. E. | |
| 3 NAME OF DECEASED (Type or print) David G. LASHER | | 4 DATE OF DEATH Month DECEMBER Day 12 Year 19 66 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5 SEX MALE | 6 COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH AUGUST 8, 1880 | 9 AGE (In years last birthday) 86 yrs. | 10. IF UNDER 1 YEAR Months 12 Days 19 Hours 66 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY MANFG. | | 11 BIRTHPLACE (County & State, or foreign country) NEW YORK New York | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME GEORGE LASHER | | 14. MOTHER'S MAIDEN NAME MARGARET DUTCHER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT VELMA BEYER 1907 GAYLORD DRIVE S. E. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 151X Fastigial Carcinoma DUE TO (b) pulmonary metastases DUE TO (c) stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH approx 1 yr |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | |
| 19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1965 to Dec , 19 66 that (I) (we) last saw the deceased alive on Dec 12, 19 66 , and that death occurred at 5 P M, from causes on and the date stated above. | | | | | |
| 22a. SIGNATURE John F. Shay | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN F. SHAY | | 22d. ADDRESS 5509 Old Pike Hill Rd, Suitland Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12/14/66 | | 23c. NAME OF CEMETERY OR CREMATORY LOCK BERLIN CEMETERY | |
| 23d. LOCATION (City or Town) (County) (State) LOCK BERLIN, NEW YORK | | 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME ADDRESS 4308 SUITLAND ROAD S. E. SUITLAND MD. | | | |
| 25a. REC'D BY REGISTRAR DEC 19 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 17657 | | 17651 | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillcrest Heights d. STREET ADDRESS 5009 Dixon Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last William Brewster Laughter | | | | 4. DATE OF DEATH Month Day Year 12 8 19 66 | | | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 12-31-1907 | | 9. AGE (in years last birthday) 58 5/8 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DAIRY | | | | 10b. KIND OF BUSINESS OR INDUSTRY DAIRY | | 11. BIRTHPLACE (State or foreign country) N. CAROLINA | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JESSE H. LAUGHTER | | | | 14. MOTHER'S MAIDEN NAME LYDIA MOFFITT | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. 579-03-5864 | | 17. INFORMANT Address MARY LAUGHTER SEE #2 | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - over 10 years | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs. | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22. DATE SIGNED 12-8-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE/THEREOF 12/12/66 | | 23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN | | 23d. LOCATION (City, town or county) (State) Bladensburg, MD. | | | |
| 24. FUNERAL DIRECTOR Address Adm. Chambers Co. 577 N. 45th St | | | | 25a. REC'D BY REGISTRAR DEC 12 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17658

CERTIFICATE OF DEATH

17652

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D. C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN 1b 3 yr. 2 mo. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | e. STREET ADDRESS 511 5th St., N.W. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Susie Lawrence | | 4. DATE OF DEATH Month Day Year 12/7/ 19 66 | |
| 5. SEX F | 6. COLOR OR RACE N | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/5/86 |
| 9. AGE (in years last birthday) 80 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 19 66 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (County & State, or foreign country) Va. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Austin Tate | | 14. MOTHER'S MAIDEN NAME Betty ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Perforation of duodenal ulcer DUE TO (c) Multiple duodenal ulcers (with penetration into the pancreas) | | | INTERVAL BETWEEN ONSET AND DEATH 1 week |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) diabetes mellitus; left radical mastectomy for carcinoma of the breast 11/63; total hysterectomy, 12/63; chronic pyelonephritis. | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 10/14/ 63 to 12/7/66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/7/ 19 66 , and that death occurred at 6:15 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/7/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/14/66 | 23c. NAME OF CEMETERY OR CREMATORY Church Cemetery | 23d. LOCATION (City or Town) (County) (State) Westmorland City, Va. |
| 24. FUNERAL DIRECTOR Lowes. F. Home. 1425 m.dave. | | 25a. REC'D BY REGISTRAR DATE DEC 14 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

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17659

CERTIFICATE OF DEATH

17653

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN 1b 2 Months | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home | | e. STREET ADDRESS 915- Palmer Road SE | |
| 3. NAME OF DECEASED (Type or print) ALBERT LEBERT | | 4. DATE OF DEATH Month Dec. Day 7th Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 20- 1901 |
| 9. AGE (In years last birthday) 65 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Potomac Electric Power Company | | 11. BIRTHPLACE (County & State, or foreign country) New Jersey | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Oliver Lebert | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Frazerd | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT Address Kenneth A. Lebert (Son) Same as # 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis from DUE TO (c) Carcinoma of Prostate | | INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo 11 mo | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 10/18/66 to 12/7/66 that (I) (we) last saw the deceased alive on 12/6/66 , and that death occurred at 7 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Kelvin L. Minchin | | 22b. DATE SIGNED 12/7/66 | |
| 22c. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN | | 22d. ADDRESS 6400 MARLBORO PIKE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 10-1966 | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | 23d. LOCATION (City or town) (County) (State) Broadcreek, Maryland |
| 24. FUNERAL DIRECTOR Simmons Bros. | | 25a. REC'D BY REGISTRAR DEC 12 1966 | |
| ADDRESS 1661- Gd. Hope Rd. SE. Wash., DC | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

17660

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #23 & 14 Film #G393 12/15/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17654

| | | | |
|---|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington | |
| b. CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DCA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 1224 C St., N.W. | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Randolph M. Lee | | 4 DATE OF DEATH Month Day Year 12 3 19 66 | |
| 5 SEX M | 6 COLOR OR RACE Negro | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 4 Mar., 1901 |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b KIND OF BUSINESS OR INDUSTRY Contractor | 9 AGE (In years last birthday) yrs 55 |
| 11 BIRTHPLACE (State and country) W.C. | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME Moses Lee | | 14 MOTHER'S MAIDEN NAME Minnie Glechmond | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO | |
| 17. INFORMANT Carrie Lee | | Address 1234 E St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Shock DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Laceration of abdominal wall and amputation of rt leg. DUE TO (c) Trauma auto accident | | | INTERVA. BETWEEN ONSET AND DEATH Minutes |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Struck by auto | |
| 20c TIME OF INJURY Month, Day, Year Hour:Min 10:45 pm 12 3 19 66 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Balt. Wash Parkway nr rt 212, P.G. | 20f (City or town) (County) (State) Md. |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Rehoe, M.D. | | 22. DATE SIGNED 12-5-66 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12-9-66 | |
| 23c NAME OF CEMETERY OR CREMATORY Church | | 23d LOCATION (City or Town) (County) (State) Farmville, Va | |
| 24 FUNERAL DIRECTOR W. H. Bacon | | 25a REC'D BY REGISTRAR 1722 7th Ave | |
| 25b REGISTRAR'S SIGNATURE Charles Judge | | DATE DEC 7 1966 | |

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

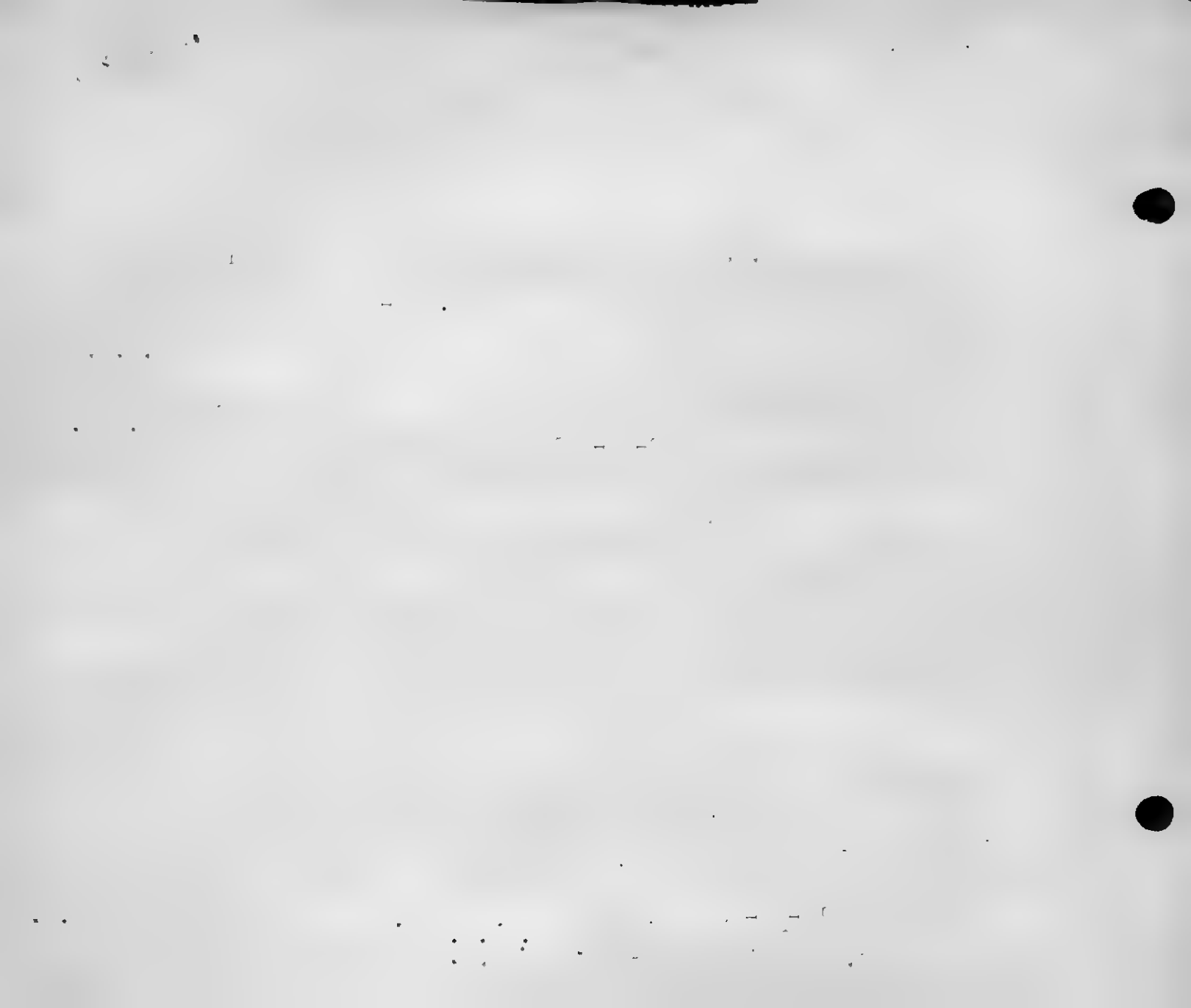
17661

CERTIFICATE OF DEATH

17655

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYATTSVILLE | | | |
| c. LENGTH OF STAY IN b. 9 years | | | | d. STREET ADDRESS 8910 RIGGS ROAD | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8910 RIGGS ROAD | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) MARIE LUISE LESSARD (MOTIER ST. JEAN BAPTISTE DELASALLE) | | | | 4. DATE OF DEATH 12 8 19 66 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH JAN. 13-80 | |
| 9. AGE (In years last birthday) 86 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EDUCATION | | 11. BIRTHPLACE (County & State, or foreign country) CANADA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HENRY LESSARD | | | | 14. MOTHER'S MAIDEN NAME MATHILDA ROBITAILLE | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. 220-54-0214 | | | |
| 17. INFORMANT Mother Agnes | | | | Address HATTS. MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive Heart Failure DUE TO (b) Hypertensive cardiovascular disease DUE TO (c) 54 years | | | | INTERVAL BETWEEN ONSET AND DEATH 48 hrs. | | | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JAN. 2 1966 to Dec. 8 1966 that (I) (we) last saw the deceased alive on Dec. 8 1966 , and that death occurred at 8:57 A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE James L. Haubach, M.D. | | | | 22b. DATE SIGNED 1963 Wooded way, Adelphi, Md. | | 22c. PHYSICIAN'S NAME (Type) James L. Haubach, MD | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE THEREOF 12-10-66 | | 23c. NAME OF CEMETERY OR CREMATORY VILLA AUGUSTINA CEM. | | 23d. LOCATION (City, town or county) (State) GOFFSTOWN, N.H. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins | | | | 25a. REC'D BY REGISTRAR DEC 13 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in items 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17662

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17656

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN 1b <u>DCA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> d. STREET ADDRESS <u>4-M Laurel Hill</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Elizabeth</u> Last <u>Lorentz</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>4</u> Year <u>1966</u> | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>6-6-06</u> | |
| 9. AGE (In years last birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ice cream co.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Robert Lindsay</u> | | 14. MOTHER'S MAIDEN NAME <u>Laura Queen</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>579 16 0975</u> | |
| 17. INFORMANT <u>Paul Lorentz</u> | | Address <u>Greenbelt, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction and aspiration of</u> DUE TO <u>gastric contents, and</u> (b) <u>Infarction of small intestine due to fibrous</u> DUE TO <u>adhesions and linking.</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | 22. DATE SIGNED <u>12-6-66</u> | |
| EXAMINER'S NAME (Type) <u>John Kehoe M.D., Riverdale, Maryland</u> | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec 7, 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | 25a. REC'D BY REGISTRAR <u>DEC 8 1966</u> | |
| ADDRESS <u>Hyattsville, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

17663

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17657

| | | | |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. LENGTH OF STAY IN 1b <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | d. STREET ADDRESS <u>5450 Newton Street, Apt. 6</u> | |
| 3 NAME OF DECEASED (Type or print) <u>David Lewis Lugo</u> | | 4 DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W. DOWED <input type="checkbox"/> D. VORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>25 Sept. 1966</u> |
| 9. AGE (In years last birthday) yrs <u>3</u> | | 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>19</u> Hours <u>66</u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>LOUIS LUGO</u> | | 14. MOTHER'S MAIDEN NAME <u>MARGIE BOWEN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT <u>LOUIS LUGO</u> | | Address <u>SAME AS #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Interstitial pneumonitis</u> DUE TO (c) <u>SDII</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE IMMEDIATE CAUSE OF DEATH (Enter nature of injury in Part I or Part II of item 18) <u>INTERMITTENT ASTHMA</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kohoe, M.D.</u> | | 22. DATE SIGNED <u>12-25-66</u> | |
| EXAMINER'S NAME (Type) <u>John Kohoe, M.D.</u> | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>27 DEC 1966</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>WASHINGTON, D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>W. W. Chambers & Co. Riverdale, Md.</u> | | 25. HELD BY REGISTRAR <u>DEC 30 1966</u> | |
| 25a. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u> | | 25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u> | |

17664

CERTIFICATE OF DEATH

17658

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE'S | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY IN 1b 5HR 45MIN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp.to give street address) USAF HOSPITAL ANDREWS | | d. STREET ADDRESS 3018 PARKWAY TERRACE DRIVE | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY (NMN) MAC DONALD | | 4. DATE OF DEATH Month Day Year DECEMBER 7 19 66 | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7 DEC 66 |
| 9. AGE (In years last birthday) yrs. | | 10. UNDER 1 YEAR Months Days | 11. UNDER 24 HRS Hours Min. 5 45 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (County & State, or foreign country) PRINCE GEORGE'S MD. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME JAMES JOSEPH MAC DONALD | | 14. MOTHER'S MAIDEN NAME TAKA (NMN) OGATA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A | | 16. SOCIAL SECURITY NO. N/A | |
| 17. INFORMANT JAMES J MAC DONALD-FATHER-SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY ARREST 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PREMATUREITY DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 5HR 45MIN | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 7 DEC 1966, to 7 DEC 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 7 DEC 1966, and that death occurred at 4:15 P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE Paul G. Perlstein | | 22b. DATE SIGNED 7 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) PAUL G. PERLSTEIN, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/27/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l | | 23d. LOCATION (City or Town) (County) (State) Arlington, VA. | |
| 24. FUNERAL DIRECTOR Will Chambers Co. 5721 11th ST SE | | 25a. REC'D BY REGISTRAR DEC 12 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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17665

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17659

| | | | | | | | |
|--|----------------------------------|--|---|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. LENGTH OF STAY IN ID <u>DCA</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | d. STREET ADDRESS <u>7770 Hawthorne Street</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Frederica Kane Maloney</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>1966</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>24 Nov. 1913</u> | 9. AGE (In years last birthday) <u>53</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>12</u> Days <u>13</u> Hours <u>19</u> Min. <u>66</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone Operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | | 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John Kane</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Marie Purcell</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>100 18 0276</u> | | 17. INFORMANT <u>Richard J. Calistri</u> Address <u>Same as #2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> | | | | 22. DATE SIGNED <u>12-13-66</u> | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u> | | | | Address (Street, city, town, or county) <u>Riverdale, Md.</u> | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>12/17/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. James</u> | | 23d. LOCATION (City, town or county) (State) <u>Waverly</u> <u>N. Y.</u> | |
| 24. FUNERAL DIRECTOR <u>Francis Gasch's Sons</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u> | | | |
| ADDRESS <u>Hyattsville, Md.</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed with in 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and at any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|---|---|--|---|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 17666 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 17660 | | | |
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Howard | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | | c. LENGTH OF STAY IN lb three hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | | | | d. STREET ADDRESS 720 Dunlogan Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Fitz - Hugh B. Marshall, Jr. | | | | | 4. DATE OF DEATH Month 12 Day 2 Year 1966 | | | | |
| 5. SEX male | | 6. COLOR OR RACE white | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 3-5-12 | | 9. AGE (In years last birthday) 54 yrs | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physicist | | | 10b. KIND OF BUSINESS OR INDUSTRY Westinghouse | | 11. BIRTHPLACE (State or foreign country) New Mexico | | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Fitz-Hugh B. Marshall, Sr. | | | | | 14. MOTHER'S MAIDEN NAME Late Lola | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 174-22-6546 | | 17. INFORMANT Mrs. Genevieve Marshall Address 270 Dunloggin Rd. Ellicott City, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 8164 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma - auto accident DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) passenger in car involved in collision | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. 6:00pm p.m. 12-2 1966 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S.#1, Beltsville, Beltsville, Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 5, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | | 23d. LOCATION (City or town) (County) (State) Ellicott City Howard Md. | | |
| 24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pk., Ellicott City, Md. | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17667

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17661

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a COUNTY Prince George's b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale c LENGTH OF STAY IN 1b DOA | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Howard | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | d STREET ADDRESS 720 Dunloggan Road | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Paul Norman Marshall | | 4 DATE OF DEATH Month Day Year 12 2 1966 | |
| 5 SEX Male 6 COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 1-11-17 9. AGE (In years last birthday) 19 yrs | |
| 10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Pittsburgh, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13 FATHER'S NAME The late Fitz-Hugh B. Marshall | | 14 MOTHER'S MAIDEN NAME Genevieve | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO 216-46-2023 | |
| 17 INFORMANT Mrs. Genevieve Marshall, 720 Dunloggan Rd. | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Laceration of brain 816.4 DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma - auto accident DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) driver of car involved in collision | |
| 20c TIME OF INJURY Month, Day, Year 6:00pm 12-2 1966 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office building, etc.) U.S. Route 1 | | 20f (City or town) (County) (State) Beltsville, P.G., Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Rehoe M.D., Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 22. DATE SIGNED 12-3-66 | | | |
| 23a BURIAL, CREMATION, REMOVAL, (Specify) Burial | | 23b DATE THEREOF Dec. 5, 1966 | |
| 23c NAME OF CEMETERY OR CREMATORY St. Johns Cemetery | | 23d LOCATION (City or Town) (County) (State) Ellicott City Howard Md. | |
| 24. FUNERAL DIRECTOR Harry H. Witzke, 321 Columbia Pk., Ellicott City, Md. | | 25a. REC'D BY REGISTRAR DEC 5 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17568

CERTIFICATE OF DEATH

17662

| | | | | | | | |
|---|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. George Co.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | | | c. LENGTH OF STAY IN 1b <u>2 DAYS</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HYATTSVILLE NURSING HOME</u> | | | | e. STREET ADDRESS <u>2104 BANNING PLACE 16.1</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE</u> <u>FREDERICK</u> <u>MARTIN</u> | | | | 4. DATE OF DEATH Month Day Year <u>DEC.</u> <u>7</u> <u>1966</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>AUG. 5, 1895</u> | 9. AGE (In years last birthday) <u>71</u> yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUPERINTENDENT (RETIRED)</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERY</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON, D.C.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | 13. FATHER'S NAME <u>GEORGE MARTIN</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>CHRISTIANNA MANNBOLD</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | |
| 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | 17. INFORMANT <u>Miss IRENE E. MARTIN - 2104 BANNING PLACE</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MARCH</u> , 19 <u>66</u> , to <u>Dec.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>66</u> , and that death occurred at <u>5:10 AM</u> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Bernard A. Fitzgerald</u> | | | | 22b. DATE SIGNED <u>12-7-1966</u> | | 22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u> | |
| 22d. ADDRESS <u>217 UNIVERSITY BLVD E. - SIL SPR MD</u> | | | | 23a. REC'D BY REGISTRAR <u>Charles Judge</u> | | | |
| 23b. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23c. DATE THEREOF <u>12/10/1966</u> | | 23d. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u> | | 23e. LOCATION (City, town or county) (State) <u>SUITLAND & R. Co. MD</u> | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS INC - SILVER SPRING, MD</u> | | | | 25a. DATE <u>DEC 9 1966</u> | | | |

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17669

CERTIFICATE OF DEATH

17663

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c. LENGTH OF STAY IN b 6 mos., 25 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | e. STREET ADDRESS 518 Peabody St., N. W. | |
| 3. NAME OF DECEASED (Type or print) First Hattie Middle -- Last Matthews | | 4. DATE OF DEATH Month 12 Day 26 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/2/1880 |
| 9. AGE (In years last birthday) 86 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown (retired) | | 10b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Alexandria Morton | | 14. MOTHER'S MAIDEN NAME Rosie Whiting | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 579-12-1251 | |
| 17. INFORMANT D.C. General Hospital and daughter, Mrs. Margaret McFadden, 908 Division Ave., N.E. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebrovascular accident (thrombosis) DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Generalized arteriosclerosis | | INTERVAL BETWEEN ONSET AND DEATH 2 days unknown unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from 6/1/1966 , to 12/26/1966 , that (X) (we) last saw the deceased alive on 12/26/1966 , and that death occurred at 9:00 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Moe Weiss | | 22b. DATE SIGNED 12/26/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23. BURIAL, CREMATION, REMOVAL (Specify) 12-30-66 | | 23b. DATE THEREOF 12-30-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony Park | | 23d. LOCATION (City or Town) (County) (State) Highland Park Md | |
| 24. FUNERAL DIRECTOR H.S. Washington & Sons 4925 Deale C-6 | | 25a. REC'D BY REGISTRAR JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE Glenn Dale, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17670

CERTIFICATE OF DEATH

17664

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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|--|----------------------------------|---|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | | c. LENGTH OF STAY in 1b Life | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 611 10th Street | | | | d. STREET ADDRESS 611 10th Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Rose Ethel Matthews | | | | 4. DATE OF DEATH Month December Day 1 Year 1966 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 24, 1918 | | 9. AGE (In years last birthday) 48 yrs | 10. IF UNDER 1 YEAR Months 4 Days 18 Hours 48 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ho sewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Preston Johnson | | | | 14. MOTHER'S MAIDEN NAME Amelia Harrison | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Kermit E. Matthews | | Address Item #12 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) Acute Pulmonary Oedema DUE TO (b) Generalized Carcinomatosis DUE TO (c) Adeno-carcinoma of the left breast | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) was not present attended the deceased from 1955 , to Dec 1, 1966 , that (I) (we) last saw the deceased alive on Dec. 1, 1966 , and that death occurred at 9:10 A.M. causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Robert C. Wingfield, MD. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Dec. 1, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Robert C. Wingfield, MD. | | | | 22d. ADDRESS Frederick, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/5/66 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore National | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR Robert L. A. Rockville, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 7 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17671

CERTIFICATE OF DEATH

17665

| | | | | | |
|--|-------------------------------|--|------------------------------------|---|--|
| 1 PLACE OF DEATH a. COUNTY Pr. Geo. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Pr. Geo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lanham | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pr. Geo. Gen. Hosp. | | | | d. STREET ADDRESS 9324 Defence Highway | |
| 3 NAME OF DECEASED (Type or print) Orrie Gay Maxwell | | 4. DATE OF DEATH Dec. 29 1966 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8 Mar 1893 | | 9. AGE (In years last birthday) 73 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY Construction | | 11 BIRTHPLACE (County & State, or foreign country) Washington, D. C. | |
| 13. FATHER'S NAME Essel Stewart | | 14. MOTHER'S MAIDEN NAME Cordelia Stewart Thompson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO 579 14 6963 | | 17. INFORMANT Mary L. Maxwell Address Wife Same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Thrombosis with Anterior myocardial infarction DUE TO (b) Arteriosclerotic heart infarction DUE TO (c) Generalized arteriosclerosis | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/8 1955 , to 12/29 1966 , that (I) (we) last saw the deceased alive on 12/26 1966 , and that death occurred at 5:15 P.M. from causes and on the date stated above | | | | | |
| 22a. SIGNATURE H. James Kutz | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/30/66 | |
| 22c. PHYSICIAN'S NAME (Type) H. James Kutz | | 22d. ADDRESS Glen Dale, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1/3/67 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | |
| 23d. LOCATION (City or Town) Colmar Manor | | (County) Maryland | | (State) | |
| 24. FUNERAL DIRECTOR F. Fasch's Sons | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE W. J. Dudge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17672

CERTIFICATE OF DEATH

17666

| | | | |
|---|---------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) iverdale, Md. | | c. LENGTH OF STAY IN 1b 6 hrs 16 min | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Island Memorial Hospital | | d. STREET ADDRESS 1111 20th St. (S.E. Washington D.C.) | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Caroline Mc Burney | | 4. DATE OF DEATH Month Day Year December 29 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/25/10 |
| 9. AGE (In years last birthday) yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W. | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Greenwald | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mrs. H.R. Trott | | Address 5118-26th Ave. Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic & Hypertensive Cardiovascular Disease DUE TO (c) Arteriosclerosis Generalized | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 15 years 25 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 30, 1953, to Dec. 29, 1966, that (I) (we) last saw the deceased alive on December 28, 1966, and that death occurred at 5:16 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Walcott W. Gibson | | 22b. DATE SIGNED December 29, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Walcott W. GIBSON, M.D. | | 22d. ADDRESS 4300 St. Barnabas Road, Marlow Hts. Md. (via D.C. 200) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec. 31, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORIUM Hebazon Church | | 23d. LOCATION (City or Town) (County) (State) West Mifflin, Pa. | |
| 24. FUNERAL DIRECTOR F. G. Sch's South Hyattsville, Md | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE John J. Jones | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17573

CERTIFICATE OF DEATH

17667

| | | | |
|---|--------------------------|--|----------------------------------|
| 1 PLACE OF DEATH a COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b. COUNTY Pro Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Adelphi Md | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum Heights, Md. | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paint Branch Nursing Home | | d STREET ADDRESS 5931 15th avenue | |
| 3 NAME OF DECEASED (Type or print) Catherine Q. McClintock | | 4. DATE OF DEATH Month Dec 9, Day Year 1966 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Dec. 21, 1870 |
| 9 AGE (In years birthday) yrs 95 | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) house wife | | 10b KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11 BIRTHPLACE (County & State, or foreign country) England | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME John Quinton | | 14 MOTHER'S MAIDEN NAME Mary A. Sheehan | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO. 219 54 8292T | |
| 17 INFORMANT Mary L. Freysz | | Address Chillum Heights, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis (c) INTERVAL BETWEEN ONSET AND DEATH 2-3 hours year | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1963, 19 to 12-9, 1966, that (I) (we) last saw the deceased alive on 12-7, 1966, and that death occurred at 6:00 P.M. from causes and on the date stated above. | | | |
| 22a SIGNATURE Donald C. Eggen M.D. | | 22b. DATE SIGNED 12-10-66 | |
| 22c. PHYSICIAN'S NAME (Type) DONALD C. EGGREN | | 22d ADDRESS Hyattsville, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 12, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DATE DEC 15 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

FOR STATE
HEALTH DEPT.

17674

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17668

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|------------------------|--|---------------------------------|--|-------------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY in 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 6419 K St., | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Ernest Middle Eugene Last McConneyhead | | | | 4. DATE OF DEATH Month 12 Day 10 Year 19 66 | | | |
| 5 SEX M | 6 COLOR OR RACE H N | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 5 Jan., 1966 | 9 AGE (In years last birthday) 11 yrs | IF UNDER 1 YEAR Months 11 Days 4 | | IF UNDER 24 HRS Hours 1 Min |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired) NONE | | 10b. KIND OF BUSINESS OR INDUSTRY NONE | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME VERNON FRANKLIN | | | | 14. MOTHER'S MAIDEN NAME PATSY Mc CONNETHEAD | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT PATSY Mc CONNETHEAD Address 6419 K St., CEDAR HEIGHTS, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary edema SDIT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Cause undetermined (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. | | 22. DATE SIGNED 12-11-66 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/17/66 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. | | 23d. LOCATION (City or Town) (County) (State) Randall Md. | |
| 24. FUNERAL DIRECTOR Address 339 Arlene Funeral Home Inc. Hunt, NE | | | | 25a. REC'D BY REGISTRAR DATE 12 19 1966 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 387 4-13 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17669

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Prince George's | |
| b CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b DCA | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e STREET ADDRESS 6666 Walker Mill Road | |
| 3 NAME OF DECEASED (Type or print) First Middle Last James Roger McDonald | | 4 DATE OF DEATH Month 12 Day 23 Year 19 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 29 Nov. 1966 |
| 9 AGE (In years lost birthday) yrs 25 | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (State or foreign country) Md | | 12 CITIZEN OF WHAT COUNTRY? U S A | |
| 13 FATHER'S NAME Raymond F Mc Donald | | 14 MOTHER'S MAIDEN NAME Virginia Di toto | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT Raymond F Mc Donald | | Address District Heights Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) S D I I 7730 DUE TO (b) Cause of death undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | 20f (City or town) (County) (State) |
| 21. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 12-25-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | Address (Street, city, town or county) | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | 23b DATE THEREOF Jan 3, 1966 | 23c NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | 23d LOCATION (City or Town) (County) (State) Washington D C |
| 24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 25a REC'D BY REGISTRAR DATE JAN 5 1967 | |
| | | 25b REGISTRAR'S SIGNATURE Charles Judge | |

6-19814

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17676

CERTIFICATE OF DEATH

17670

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o STATE Maryland b COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b 3 days | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 4800 Berwyn House Road | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) Bernice First Middle Last M'Fadden | | 4 DATE OF DEATH December 17, 1966 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 10/29/20 | 9 AGE (In years last birthday) 46 yrs. |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b KIND OF BUSINESS OR INDUSTRY U.S. Government | 11 BIRTHPLACE (County & State, or foreign country) Oklahoma |
| 13. FATHER'S NAME William Embrey | | 14. MOTHER'S MAIDEN NAME Obera Johnson | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. | |
| 17 INFORMANT 9700 51st Place Address Lou Jean College Park, Md. (sister) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diabetes Mellitus with Diabetic coma. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction (Papillary Muscles) DUE TO (c) Coronary Arteriosclerotic Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from 12-13, 1966 , to 12-17, 1966 , that (we) lost the deceased alive on 12-17, 1966 , and that death occurred at 2:50 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE R.D. Bauer M.D. | | 22b. DATE SIGNED 12-17-66 | |
| 22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D. | | 22d. ADDRESS 2513 Buck Lodge Rd. Adelphi, Md. | |
| 23a BURIAL, CREMATION, or other final disposition (Specify) Burial | 23b. DATE THEREOF 12/20/66 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | 23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md. |
| 24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE 12 22 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE James Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17671

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admision) a. STATE Alabama b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 6 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Birmingham | | 411.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 1422 Melrose Place | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Frank L. Medearis | | 4. DATE OF DEATH Month Day Year Dec. 27 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6 June 1885 |
| 9. AGE (In years last birthday) 81 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Retail Merchant | |
| 11. BIRTHPLACE (County & State, or foreign country) Lincoln Co. Tennessee | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME Washington Davis Medearis | | 14. MOTHER'S MAIDEN NAME Lucy Allen | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. I | | 16. SOCIAL SECURITY NO 409-54-1694 | |
| 17. INFORMANT Wm. D. Medearis | | 3223 Toledo Pl. Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 332X IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-21, 1966 to 12-26, 1966 , that (I) (we) last saw the deceased alive on 12-26, 1966 , and that death occurred at 12:50 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Aaron Deitz | | 22b. DATE SIGNED 12/27/66 | |
| 22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D. | | 22d. ADDRESS Prince George's Plaza, Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF Dec. 28, 1966 | 23c. NAME OF REMOVED OR CREMATORY Ft. Lincoln Crematory | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md. |
| 24. FUNERAL DIRECTOR F. Gasch's Sons 4739, Balt. Ave. Hyattsville, Md. | | 25a. RECD BY REGISTRAR DATE DEC 29 1966 | 25b. REGISTRAR'S SIGNATURE |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17678

CERTIFICATE OF DEATH

17672

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institut an Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SUITLAND | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2216 LAKEWOOD STREET | | d. STREET ADDRESS 2216 LAKEWOOD STREET | |
| 3 NAME OF DECEASED (Type or print) CATHERINE C. MERCHANT | | 4. DATE OF DEATH Month DECEMBER Day 16 Year 1966 | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH MARCH 18, 1883 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY | 9 AGE (In years last birthday) 83 yrs |
| 11 BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME WILLIAM WINDSOR | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 215 56 9234 | |
| 17 INFORMANT OLIN L. MERCHANT | | Address SEAT PLEASANT MD 9307 WELLINGTON ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Generalized arteriosclerosis DUE TO (c) 5 years | | | INTERVAL BETWEEN ONSET AND DEATH 5 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21 I certify that (I) (this hospital) attended the deceased from 5-31, 1966 , to 12-16, 1966 , that (I) (we) last saw the deceased alive on 12-15, 1966 , and that death occurred at 11 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE David L. Gordon, MD | | 22b. DATE SIGNED 12-16-66 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12/19/66 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | 23d. LOCATION (City or Town) (County) (State) PRINCE GEORGES, MARYLAND |
| 24. FUNERAL DIRECTOR WILHELM FUNERAL HOME 4308 SUITLAND RD., SUITLAND MD. | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

17679

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17673

| | | | | | |
|---|---------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 5 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colmar Manor | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS 3813 40th. Avenue | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Everett Gilbert Miller | | | 4. DATE OF DEATH Month Day Year 12 20 1966 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 29 April 1915 | 9. AGE (In years last birthday) 51 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician | | 10b. KIND OF BUSINESS OR INDUSTRY Central Co | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 13. FATHER'S NAME Albert Miller | | | 14. MOTHER'S MAIDEN NAME Jessie Alma Dearing | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 6. SOCIAL SECURITY NO 224 14 5347 | | 17. INFORMANT Kenneth Miller Seat Pleasant, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Subdural hematoma 1369 DUE TO Fracture of skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) undetermined | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. unknown unknown | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, or neighborhood, etc.) unknown | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | |
| 22. DATE SIGNED 12-22-66 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 23, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | 25a. REC'D BY REGISTRAR DEC 27 1966 | | 25b. REGISTRAR'S SIGNATURE |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1000



17680

CERTIFICATE OF DEATH

17674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. LENGTH OF STAY IN 1b <u>19 months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>6700 Belcrest Road</u> | | d. STREET ADDRESS <u>6700 Belcrest Road</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Curtis</u> Last <u>Minier</u> | | 4. DATE OF DEATH Month <u>December</u> Day <u>14</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 16, 1889</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>G.P.O. U. S. Govt.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>Townsend Minier</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Ort</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO <u>579-52-6622</u> | |
| 17. INFORMANT <u>Mrs. Margaret Minier</u> | | Address <u>6700 Belcrest Rd. Hyattsville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u> </u> Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>66</u> , to <u>12-14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>66</u> , and that death occurred at <u>7:30 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Charles U. Pate</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED <u>12-14-66</u> |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles U. Pate</u> | | 22d. ADDRESS <u>3335 Jennyson St., N. W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec. 17, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Port Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Barner E. Humphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |
| ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> | | DATE <u>DEC 13 1966</u> | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17681

17675

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. LENGTH OF STAY IN 1b 12 DAYS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT BELVOIR | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | |
| e. STREET ADDRESS 906 A DOGUE CREEK | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARCIA CELESTE MOORE | | 4. DATE OF DEATH DECEMBER 8 19 66 | |
| 5. SEX FEMALE | 6. COLOR OR RACE NEGROID | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 21 MAY 1962 |
| 9. AGE (In years last birthday) 4 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) N/A | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME FEINSTER MILES MOORE JR | | 14. MOTHER'S MAIDEN NAME BERNICE LUZETTA TRUESDALE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A | | 16. SOCIAL SECURITY NO N/A | |
| 17. INFORMANT FEINSTER M. MOORE JR-FATHER-SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO (b) <u>SICKLE CELL ANEMIA & CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>OVERWHELMING SEPSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 4 YEARS 2 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) | | 19. WAS A TUPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from <u>25 NOV</u> , 19 <u>66</u> , to <u>8 DEC</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>8 DEC</u> , 19 <u>66</u> , and that death occurred at <u>2:00 M</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Roger E. Spitzer, M.D.</u> | | 22b. DATE SIGNED 8 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) ROGER E. SPITZER, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12-13-66 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY | 23d. LOCATION (City or Town) (County) (State) ARLINGTON, VIRGINIA |
| 24. FUNERAL DIRECTOR <u>John T. Rhoads</u> | | 25a. REC'D BY REGISTRAR DATE DEC 15 1966 | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1997

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17682

CERTIFICATE OF DEATH

17676

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince Geo | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boulevard Heights | | c. LENGTH OF STAY IN 1b 5 yrs | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boulevard Heights |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4808 Boulevard Heights | | d. STREET ADDRESS 4808 Alton Street S.E. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Martha E. Moore | | 4. DATE OF DEATH Month Day Year December 27 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH Dec 30, 1896 |
| 9. AGE (In years last birthday) yrs 69 | | 10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) West Virginia | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Walter Beck | | 14. MOTHER'S MAIDEN NAME Mattie Marshall | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Nellie Marsden | | Address Same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2-3 years</u> <u>2-3 yrs</u> <u>2</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>15 Nov</u> , 19 <u>66</u> , to <u>25 Dec</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>23 Dec</u> , 19 <u>66</u> , and that death occurred at <u> </u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>James B. Moffett</u> | | 22b. DATE SIGNED <u>27 Dec '66</u> | |
| 22c. PHYSICIAN'S NAME (Type) James B. Moffett | | 22d. ADDRESS 1125 Rockville Pike Rockville Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12/30/1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Seabrook Hill</u> | 23d. LOCATION (City or Town) (County) (State) <u>Switzland Md</u> |
| 24. FUNERAL DIRECTOR <u>Robert Mattingly</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 3 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17683

CERTIFICATE OF DEATH

17677

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills | | c. LENGTH OF STAY in lb 18 years | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3905 72nd avenue | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover Hills, Md. | |
| f. STREET ADDRESS 3905 72nd avenue, . | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) THURSTON ROBERT MORRIS | | 4. DATE OF DEATH Month December Day 19 Year 66 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 11, 1918 |
| 9. AGE (In years last birthday) 48 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic | | 10b. KIND OF BUSINESS OR INDUSTRY Truck | |
| 11. BIRTHPLACE (County & State, or foreign country) Culpeper Co Va | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Robert Morris | | 14. MOTHER'S MAIDEN NAME Annie Herman | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W W 11 | | 16. SOCIAL SECURITY NO 577 38 6140 | |
| 17. INFORMANT Sarah S Morris | | Address Landover Hills, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 years (c) | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 previous myocardial infarctions | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 1966, to Dec 19 , 1966 that (I) (we) last saw the deceased alive on 10 Dec 1966 and that death occurred at 4:45 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Thomas G. Maloney | | 22b. DATE SIGNED 19 Dec 66 | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS G. MALONEY M.D. | | 22d. ADDRESS 4814-71st Ave. Hyattsville Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 22, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DEC 23 1966 | | 25b. REGISTRAR'S SIGNATURE inc. J. J. J. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12/19/66 Sh Kehoe notified & approved

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17684

17674

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any other event, within 72 hours after death.

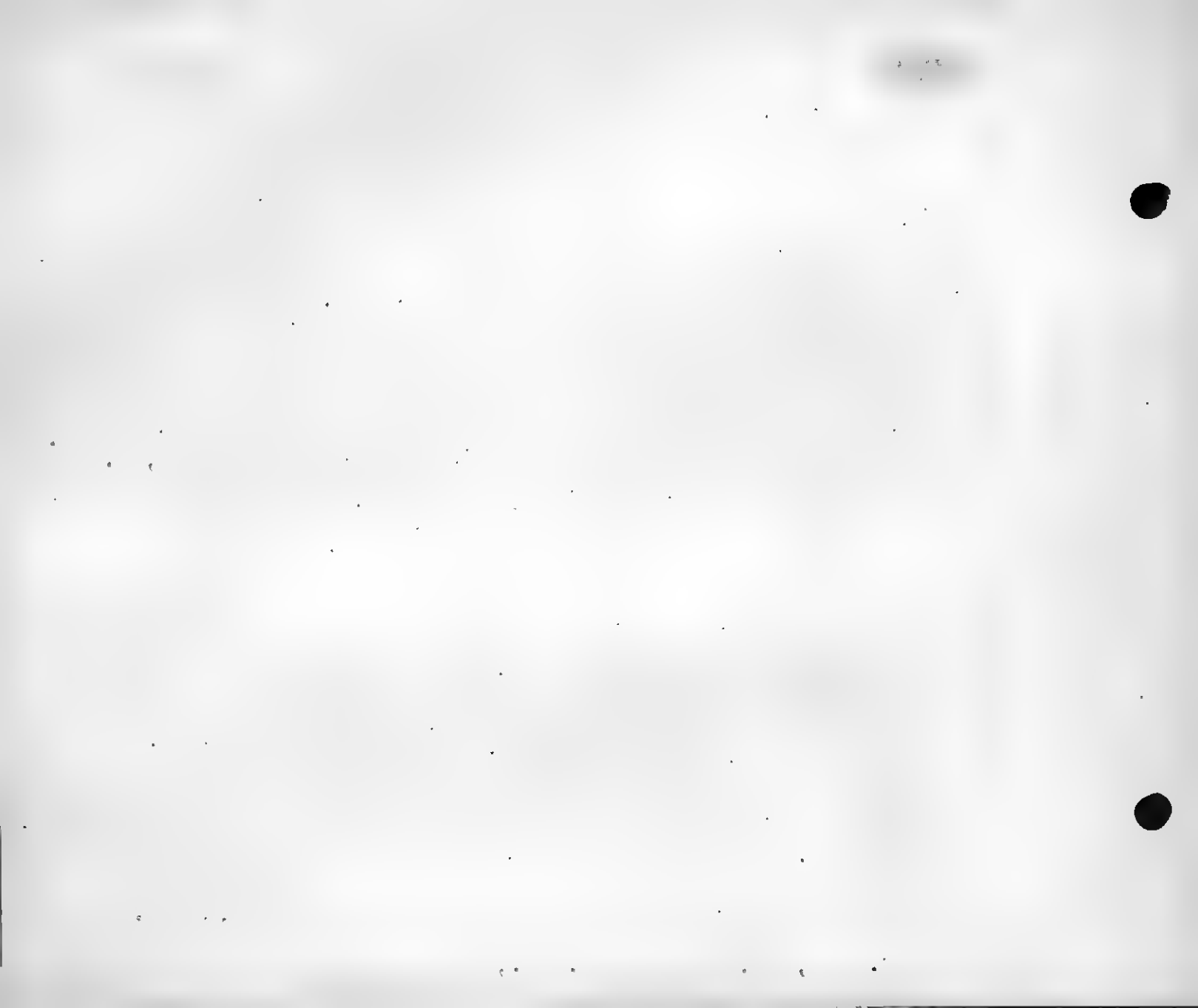
| | | | | | | | |
|---|---------------------------|---|------------------------------|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE D.C. Md. b. COUNTY Prince Georges | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forrestville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing Home | | | | d. STREET ADDRESS 5006 N St. S.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ida E. Mountcastle | | | | 4. DATE OF DEATH Month Day Year 12 3 19 66 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-3-1882 | | 9. AGE (In years last birthday) yrs 84 | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Penn. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edmond Melven | | | | 14. MOTHER'S MAIDEN NAME Emma Schulke | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Edwin H. Mountcastle Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 260X IMMEDIATE CAUSE (a) <i>Coronary Heart Failure</i> DUE TO (b) <i>Coronary artery Disease</i> stating the underlying cause last (c) <i>Diabetes Mellitus & Lymphatic Leukemia</i> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Inoperable Ventral Hernia - Lymphomatous</i> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I, or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-2-1966, to 11-3-1966, that (I) (we) last saw the deceased alive on 11-2-1966, and that death occurred at M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>James J. P. P. M.D.</i> M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 11-3-66 | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS 7200 Marlboro Ave. District Heights, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-6-66 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland, Md. | |
| 24. FUNERAL DIRECTOR Lee Funeral Home | | | | 25a. REC'D BY REGISTRAR Washington, D.C. | | 25b. REGISTRAR'S SIGNATURE DEC 7 1966 <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

| <div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>V</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u> | | | | c. LENGTH OF STAY IN lb <u>2 MONTHS</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HYATTSVILLE NURSING HOME - 6500 RIGGS RD.</u> | | | | | | d. STREET ADDRESS <u>2801 JENNA AVE S.E.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>W</u> Last <u>NESLINE</u> | | | | | | 4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>16</u> Year <u>1966</u> | | | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>DEC 20, 1882</u> | | 9. AGE (in years last birthday) <u>83</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAVERN OWNER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>TAVERN</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>George Nesline</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Anna Gerneth</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>No</u> | | 17. INFORMANT <u>George Nesline</u> Address <u>4508 Edgefield Rd. Kensington, Md.</u> | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS</u> (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>CARDIAC DECOMPENSATION</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARDIAC DECOMPENSATION</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (the hospital) attended the deceased from <u>SEPT. 6, 1966</u> to <u>DEC 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>DEC 16, 1966</u> , and that death occurred at <u>10:57 A.M.</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>WILLIAM J. DIPIERRO</u> | | | | | | 22b. DATE SIGNED <u>DEC 16, 1966</u> | | 22c. PHYSICIAN'S NAME (Type) <u>WILLIAM J. DIPIERRO</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | | | 23b. DATE THEREOF <u>12/19/66</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>James T. Ryan, Inc.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>317 Pa. Ave., SE DC</u> | | 25b. REGISTRAR'S SIGNATURE <u>James T. Ryan, Inc.</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17686

CERTIFICATE OF DEATH

17681

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORESTVILLE | | c. LENGTH OF STAY IN 1b FORESTVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7441 KEYSTONE LANE | | d. STREET ADDRESS 7441 KEYSTONE LANE | |
| 3 NAME OF DECEASED (Type or print) HULDA C. NEWHOUSE | | 4. DATE OF DEATH Month DECEMBER Day 4 Year 19 66 | |
| 5 SEX FEMALE | 6 COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH DEC. 12, 1897 |
| 9 AGE (in years lost birthday) yrs 68 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State or foreign country) PENNSYLVANIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | 13 FATHER'S NAME WILLIAM REED | |
| 14. MOTHER'S MAIDEN NAME UNKNOWN | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO. 173-18-6068 | | 17. INFORMANT Address Mary A. Reed 7441 Keystone Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 154X Congestive Heart Failure DUE TO (b) Rectal Carcinoma - metastases DUE TO (c) Pulmonary Edema | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12-4-66 , 19 to 12-4 , 19 66 , that (I) (we) last saw the deceased alive on 12-4 , 19 66 , and that death occurred at 12 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE John F. Shay | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) JOHN F. SHAY | | 22d. ADDRESS 5509 Old Silver Hill Rd, Suitland Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF DEC. 8, 1966 | 23c. NAME OF CEMETERY OR CREMATORY BLAIRSVILLE CEMETERY | 23d. LOCATION (City or Town) (County) (State) BLAIRSVILLE, PENNSYLVANIA |
| 24. FUNERAL DIRECTOR ROBERT E. WILHELM FUNERAL HOME | | 25a. REC'D BY REGISTRAR DEC 6 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

FOR STATE HEALTH DEPT.

17687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17682

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (Page 5 may be retained for your files).
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in an event with a 72 hours after death.

| | | | |
|---|--------------------------|--|----------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN TB DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last William Allen Nimmo | | 4 DATE OF DEATH Month Day Year 12 11 19 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2 Oct. 1922 |
| 9 AGE (In years lost birthday) 44 yrs. | | 10 IF UNDER 1 YEAR Months Days | 11 IF UNDER 24 HRS Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Master Sgt Retired | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Army | |
| 11 BIRTHPLACE (State or foreign country) Capital Heights, Md. | | 12 CITIZEN OF WHAT COUNTRY? U. S. | |
| 13. FATHER'S NAME William Allen Nimmo | | 14. MOTHER'S MAIDEN NAME Mary Elizabeth Osborne | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes | | 16 SOCIAL SECURITY NO | |
| 17 INFORMANT Melvin M. Mueller | | Address 5305 Taussig Bladensburg Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain DUE TO Trauma - auto accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car involved in collision. | |
| 20c. TIME OF INJURY Month, Day Year Hour o m 10:58 p m 12-11-19 66 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rt. 3 north of Rt. 50, Mitchellville, Md. | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural cause <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED 12-13-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/15/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince Georges, Md. | |
| 24 FUNERAL DIRECTOR Gilbert C. Vincent 2525 | | 25a. REC'D BY REGISTRAR Wash., D. C. | |
| 25b. REGISTRAR'S SIGNATURE Bladensburg Rd., | | DATE DEC 16 1966 | |

1944

1945



1
FOH STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

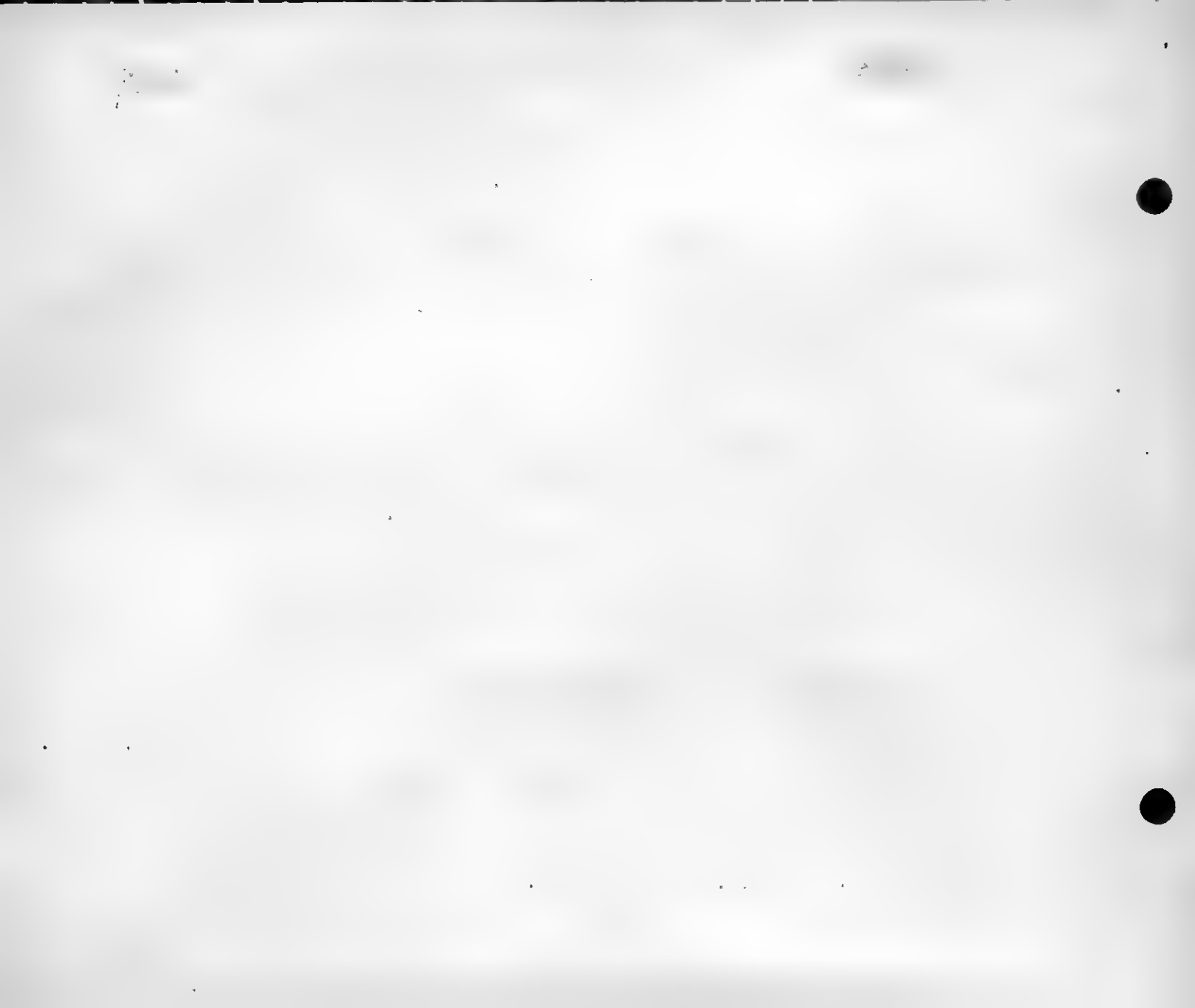
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17683

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN TB 3 hours, 20min | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 4206 43rd Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Henry L. Olden | | 4. DATE OF DEATH Month Day Year 12 1 1966 | |
| 5. SEX male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 1921 |
| 9. AGE (in years last birthday) 35 yrs | | 10. FUNDING YEAR Months Days Hours Mins | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax, right, (2500 ml.) DUE TO (b) Perforating gunshot wound of right lung DUE TO (c) Penetrating gunshot wound of right chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) shot during an argument | |
| 20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 2:40pm 12-1 1966 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) street | | 20f. (City or town) (County) (State) Bladensburg, D.C. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John M. Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) John M. Kehoe, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | Address (Street, city, town, or county) | |
| 23a. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony | | 23d. LOCATION (City or town) (County) (State) Md. | |
| 24. FUNERAL DIRECTOR C. B. [Signature] | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
21 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17689

Items 8,9 Film 334 1/4 1/66 mh

CERTIFICATE OF DEATH

Items 11,23c Film 334 1/4 1/66 mh

17684

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN it 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE CALIFORNIA b. COUNTY LOS ANGELES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOS ANGELES d. STREET ADDRESS 426 SOUTH HILL STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDDIE First HUGH Middle O'NEILL Last | | 4. DATE OF DEATH Month DECEMBER Day 14 Year 1966 | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1890 9. AGE (In years last birthday) 76 3/4 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOTEL MANAGER | | 10b. KIND OF BUSINESS OR INDUSTRY HOTEL | |
| 11. BIRTHPLACE (County & State, or foreign country) Hartford, Ct. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME HUGH O'NEILL | | 14. MOTHER'S MAIDEN NAME ELIZABETH RENEHAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1918-1919 | | 16. SOCIAL SECURITY NO. 561-36-7333 | |
| 17. INFORMANT OFFICIAL VETERANS ADMINISTRATION | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT DUE TO (b) ASHD WITH MYOCARDIAL INFARCT DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) RECORDS INTERVAL BETWEEN ONSET AND DEATH | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that X (this hospital) attended the deceased from 12 DEC , 1966, to 14 DEC , 1966 that X (we) last saw the deceased alive on 14 DEC , 1966, and that death occurred at 9:15 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE REUBEN ALTMAN, CAPT, USAF, MC | | 22b. DATE SIGNED 14 DEC 1966 | |
| 22c. PHYSICIAN'S NAME (Type) REUBEN ALTMAN, CAPT, USAF, MC | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASHINGTON DC 20331 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF 12-19-66 | 23c. NAME OF CEMETERY OR CREMATORY Hartford Vermont | 23d. LOCATION (City or Town) (County) (State) Hartford Vermont |
| 24. FUNERAL DIRECTOR W.W. Chambers Co 517-H SE Wash DC | | 25a. REC'D BY REGISTRAR DEC 19 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE J. J. Judge | |

17690

CERTIFICATE OF DEATH

17685

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE VIRGINIA b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANASSAS | |
| c. LENGTH OF STAY IN 1b 60 DAYS | | d. STREET ADDRESS 640 SUDLEY ROAD | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) LOUISE EDNA OSTASZEWSKI | | 4. DATE OF DEATH Month Day Year DECEMBER 18 19 66 | |
| 5. SEX FEMALE | 6. COLOR OR RACE CAUCASIAN | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9 APR 1915 |
| 9. AGE (In years last birthday) 51 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY N/A | |
| 11. BIRTHPLACE (County & State, or foreign country) STAUNTON, VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BERNARD HUNTER PATTON | | 14. MOTHER'S MAIDEN NAME JULIA PICKRELL | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO 578-09-1920 | |
| 17. INFORMANT JUDITH B CONNER-NIECE-SAME AS #2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 17510 INTRACEREBRAL HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC OVARIAN CARCINOMA, WIDESPREAD DUE TO (c) BILATERAL OVARIAN CARCINOMA | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS 2 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 19 OCT, 1966, to 18 DEC, 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 18 DEC 1966, and that death occurred at 10:15 from causes and on the date stated above. | | | |
| 22a. SIGNATURE Richard D. Hasz | | 22b. DATE SIGNED 10:15 A.M. 18 DEC 66 | |
| 22c. PHYSICIAN'S NAME (Type) RICHARD D HASZ, CAPT, USAF, MC Andrews AFB, Washington DC 20331 | | 22d. ADDRESS USAF Hospital Andrews | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/22/66 | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l | 23d. LOCATION (City or Town) (County) (State) Arlington, VA |
| 24. FUNERAL DIRECTOR W.A. Chambers | ADDRESS 5111 57 St | 25a. REC'D BY REGISTRAR DATE DEC 21 1966 | 25b. REGISTRAR'S SIGNATURE |

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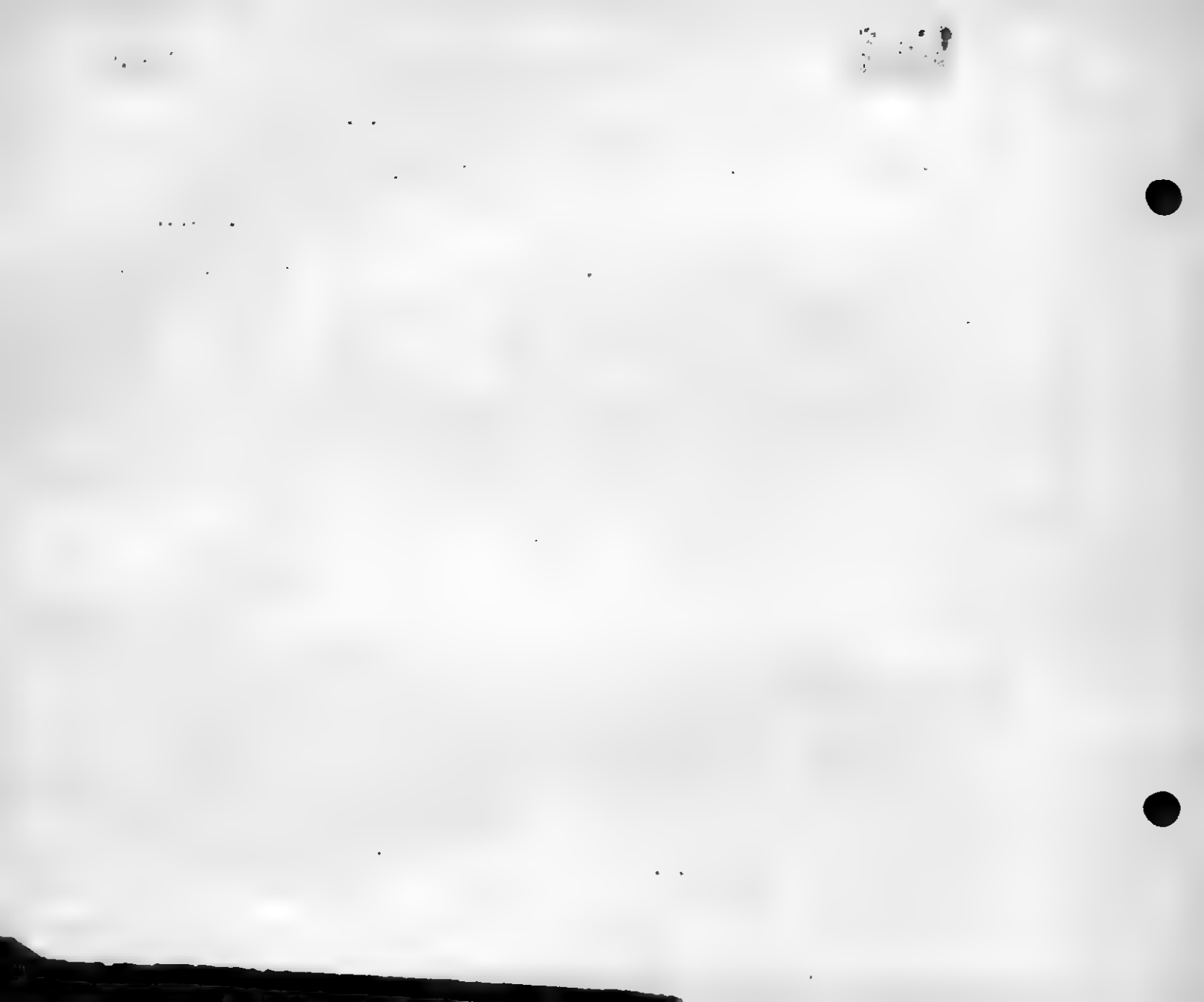
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17691

CERTIFICATE OF DEATH

17686

| | | | |
|---|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE D.C. b COUNTY <input checked="" type="checkbox"/> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c LENGTH OF STAY IN 1b 4 days | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | e STREET ADDRESS 3601 Connecticut Ave., N.W. | |
| 3 NAME OF DECEASED (Type or print) Omer H. Otto | | 4 DATE OF DEATH Month December Day 20 Year 19 66 | |
| 5 SEX male | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2/21/1906 |
| 9a. AGE (In years last birthday) 60 yrs. | | 9b. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | 10b. KIND OF BUSINESS OR INDUSTRY Indiana | |
| 11 BIRTHPLACE (County & State, or foreign country) USA | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Grisby Otto | | 14. MOTHER'S MAIDEN NAME Pearl Cox | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO unknown | |
| 17. INFORMANT decedent | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism DUE TO (b) phlebothrombosis, leg veins DUE TO respiratory insufficiency due to (c) marked pulmonary fibrosis and emphysema | | | INTERVAL BETWEEN ONSET AND DEATH sudden unknown unknown |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (X) (this hospital) attended the deceased from 12/16/ 19 66 to 12/20/ 19 66 , that (X) (we) last saw the deceased alive on 12/20/ 19 66 , and that death occurred at 1:45 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | 22b. DATE SIGNED 12/20/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 12-23-1966 | 23c. NAME OF CEMETERY OR CREMATORY New London Cemetery | 23d. LOCATION (City or Town) (County) (State) Shandon Ohio |
| 24. FUNERAL DIRECTOR Valley Funeral Home Inc. Rainier, Md | | 25a. RECD BY REGISTRAR 1966 | |
| 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | DATE | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17692

CERTIFICATE OF DEATH

17687

| | | | |
|---|--|--|---|
| 1 PLACE OF DEATH a. COUNTY <u>Pr. Georges</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHINTON</u> | | c. LENGTH OF STAY IN lb. <u>15 min.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Southern Md. General Hospital</u> | | d. STREET ADDRESS <u>CHINTON, MD</u> | |
| 3 NAME OF DECEASED (Type or print) <u>JAMES OWENS</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>28</u> Year <u>1966</u> | |
| 5. SEX <u>M</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Dec 30 1907</u> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u> | | 10b KIND OF BUSINESS OR INDUSTRY | |
| 11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James B. Owens</u> | | 14. MOTHER'S MAIDEN NAME <u>Whittie C. Thompson</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW II</u> | | 16 SOCIAL SECURITY NO <u>579-03-2570</u> | |
| 17. INFORMANT <u>Mad. Romeo H. Doss and Lane #2</u> | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>50 min.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> | |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | |
| 19 WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u> | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u> | |
| 20c TIME OF INJURY Month, Day Year <u>None</u> | 20d INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>None</u> | 20f (City or town) (County) (State) <u>None</u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1963</u> to <u>Present</u> , that (I) (we) last saw the deceased alive on <u>Sept 28 1966</u> and that death occurred at <u>6:30 AM</u> from causes and on the date stated above. | | | |
| 22a SIGNATURE <u>Arthur Shaver Jr. M.D.</u> | | 22b. DATE SIGNED <u>12/28/66</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR.</u> | | 22d ADDRESS <u>8808 BRANCH AVE - CLINTON, MD</u> | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b DATE THEREOF <u>1/2/1967</u> | |
| 23c NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Exh. Mm. Va.</u> | | 23d LOCATION (City or Town) (County) (State) | |
| 24 FUNERAL DIRECTOR <u>Joseph Mattingly</u> | | 25a REC'D BY REGISTRAR <u>JAN 3 1967</u> | |
| 25b REGISTRAR'S SIGNATURE <u>Joseph Mattingly</u> | | 25c REGISTRAR'S SIGNATURE <u>Joseph Mattingly</u> | |

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17693

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17688

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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99

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|--|--------------------------|--|---|--|---|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Peverna Park | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 101 Balsam Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Luther Samuel Palmer Sr. | | | | 4 DATE OF DEATH Month Day Year 12 23 19 66 | | | |
| 5 SEX male | 6 COLOR OR RACE white | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH 8-21-20 | 9 AGE (In years last birthday) 46 yrs | 10 IF UNDER 1 YEAR Months Days Hours Min | | 11 UNDER 24 HRS |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk Johnsons Transfer | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Alexandria, Va. | | 12 CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13 FATHER'S NAME Samuel Crawford Palmer | | | | 14 MOTHER'S MAIDEN NAME Lelia Elam | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W. W. 2 | | 16 SOCIAL SECURITY NO 230-09-2120 | | 17 INFORMANT Luther S. Palmer Jr. Address | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH unknown | | | | | | | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED Where <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office, blog, etc.) | 20f (City or town) | (County) | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | Address (Street, city, town, or county) | | 22. DATE SIGNED 12-23-66 | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE THEREOF 12/27/66 | | 23c NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington Co. Va. | | 23d LOCATION (City or town) (County) (State) | |
| 24 FUNERAL DIRECTOR Everly-Wheatley Funeral Home, Alexandria, Va. | | | | 25a REC'D BY REGISTRAR DEC 28 1966 | | 25b REGISTRAR'S SIGNATURE J Charles Judge | |

1947

1948



FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17694

17689

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allentown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Konsta Middle Paulson Last | | | | 4. DATE OF DEATH Month 12 Day 8 Year 19 66 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-10-1893 | |
| 9. AGE (In years last birthday) 73 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 11. BIRTHPLACE (State or foreign country) Finland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Paul Paulson | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Senja H. Paulson Address Same as Item #2 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 14 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | | 22. DATE SIGNED 12-8-66 | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL OR CREMATION, (Specify) | | 23b. DATE THEREOF 12-12-1966 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory | | 23d. LOCATION (City, town or county) (State) Suitland, Maryland | |
| 24. FUNERAL DIRECTOR ADDRESS Simmons Bros. 1661-Good Hope Rd SE Wash DC | | | | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 12 1966 | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7, 11, 12 Film 3503 12/12/66 mh

FOR STATE HEALTH DEPT

17695

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17690

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pen on Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN lb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville d. STREET ADDRESS 1329 Flowers Lane e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Viola M Perry 4 DATE OF DEATH Month Day Year 12 3 19 66 | | 5 SEX Female 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 28 Feb. 1902 9. AGE (In years last birthday) 64 yrs F UNDER 1 YEAR Months Days Hours M n F UNDER 24 HRS Hours M n | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA | | 13. FATHER'S NAME Thomas V. Perry 14. MOTHER'S MAIDEN NAME Mary Jones | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 3X IMMEDIATE CAUSE (a) Heart failure DUE TO Hypertensive arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | INTERVA. BETWEEN ONSET AND DEATH minutes over 3 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE John Kehoe, M.D. EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. 22. DATE SIGNED 12-4-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 12/7/66 23c. NAME OF CEMETERY OR CREMATORY Harmony 23d. LOCATION (City or town) (County) (State) 7601 Sheriff Rd. Md. | | | |
| 24. FUNERAL DIRECTOR Rollins 25a. REC'D BY REGISTRAR 4339 Hunt Pl N.E. DATE DEC 7 1966 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17696

17691

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--------------------------|--|----------------------------|--|--|---|------------------------------|
| 1 PLACE OF DEATH a. COUNTY Prince George County MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived if institution on Residence before admission) a. STATE Maryland b. COUNTY Pr. George. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN It 1 mo. 13 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing & Rehabilitative Ctr. | | | | d. STREET ADDRESS 7102-Marywood St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Doris Ann Phares | | | | 4. DATE OF DEATH Month Day Year 12 13 1966 | | | |
| 5 SEX F | 6. COLOR OR RACE Cau. | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 4/8/24 | | 9. AGE (In years lost birthday) 42 yrs. | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Co. | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (Country & State or foreign country) Caswell Co North Carolina | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Charles L. Gammon | | | | 14. MOTHER'S MAIDEN NAME Lucy Giles | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 224-28-0786 | | 17. INFORMANT Richard J. Yerak (fellow St., Hy., Md.) (Executor) | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 171X Intestinal Obstruction DUE TO (b) Metastatic Carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Originating in Cervix 6 mos | | | | INTERVAL BETWEEN ONSET AND DEATH 4 days | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Metastasis to spine hip & leg | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from 10/31/1966 to 12/13/1966 that (I) (we) last saw the deceased alive on 12/12/1966 and that death occurred at 3:55 PM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Kelvin L. Minchin M.D. | | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED 12/13/66 | |
| 22c. PHYSICIAN'S NAME (Type) KELVIN L. MINCHIN | | | | 22d. ADDRESS 6400 MARLBORO PIKE SE | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/16/66 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | | ADDRESS Mt. Rainier Maryland | | 25. REG. STRA'S SIGNATURE Charles Judge | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 264 12/22/66 mh

17697

CERTIFICATE OF DEATH

17692

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN b 26 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 3216 Chillum Road | |
| 3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Poore | | 4. DATE OF DEATH Month December Day 8 Year 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 4/4/88 |
| 9. AGE (In years) 78 (lost birthday) yrs | | 10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Charles Beavers | | 14. MOTHER'S MAIDEN NAME ? | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 217 52 6057 | |
| 17. INFORMANT Hospital records | | Address Cheverly, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1772 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 1 Year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 12, 1966 to Dec. 8, 1966 , that (I) (we) last saw the deceased alive on Dec. 8, 1966 , and that death occurred at 8:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Charles C. Hageage | | 22b. DATE SIGNED Dec. 8, 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D. | | 22d. ADDRESS 3308 Perry St. Mt. Rainier, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 12, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or town) (County) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | 25. REC'D BY REGISTRAR DATE DEC 15 1966 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17698

CERTIFICATE OF DEATH

17698

| | | | | | | | | | | | | | |
|--|---------------------------------|--|--|---|---|---|---|---|--|--------------------------------------|--|--|--|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission) a STATE Maryland b COUNTY Prince George's | | | | | | | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | c LENGTH OF STAY IN 1b | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park | | | d STREET ADDRESS 8343 Allendale Drive | | | | | | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General Hospital | | | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3 NAME OF DECEASED (Type or print) First Wallace Middle E. Last Posey | | | | 4 DATE OF DEATH Month December Day 19 Year 1966 | | | | | | | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 9/10/08 | | 9 AGE (In years last birthday) 58 yrs | 10 UNDER 1 YEAR Months Days | 11 UNDER 24 HRS. Hours Min | | | | | | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Silver Polisher | | 10b KIND OF BUSINESS OR INDUSTRY Dept Store | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U S A | | | | | | | |
| 13 FATHER'S NAME Charles F. Posey | | | | 14 MOTHER'S MAIDEN NAME Nora | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 579 09 2062 | | 17. INFORMANT Blanche V Posey | | Address Palmer Park, Md. | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Pulmonary Emboli DUE TO (c) Pneumonia | | INTERVAL BETWEEN ONSET AND DEATH 1 week 7 days | | | | | |
| | | | | | | PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| | | | | | | 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| | | | | | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/13 , 19 66 , to 12/19 , 19 66 that (I) (we) last saw the deceased alive on 12/19 , 19 66 , and that death occurred at 10:50M , from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE Dr. Till Bergemann | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/19/66 | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Till Bergemann | | | | 22d. ADDRESS Prof. Bldg., Centerway, Greenbelt, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 22, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md | | | | | | | | |
| 24 FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a REC'D BY REGISTRAR DATE DEC 23 1966 | | | | | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE J O | | | | | | | | | |

17699

CERTIFICATE OF DEATH

17694

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 4 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 2806 74th Ave | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Gertrude L Potts | | 4. DATE OF DEATH Month Day Year Dec. 13 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 19-11-1890 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Bennett F. McFarland | | 14. MOTHER'S MAIDEN NAME Addie Chesser | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Kelsa L. Potts | | Address 2806 74 th Avenue | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Hypertension DUE TO A.I.S. H.O. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1962 , to 12/13 , 1966, that (I) (we) last saw the deceased alive on 12/13 1966, and that death occurred at 3:45AM , from causes and on the date stated above | | | |
| 22a. SIGNATURE Barry Rosenberg | | 22b. DATE SIGNED 12/13/66 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Barry Rosenberg | | 22d. ADDRESS 6501 Landover Road, Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-16-1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home | | 25a. REC'D BY REGISTRAR DEC 19 1966 | |
| ADDRESS 4308 Suitland Rd Suitland Maryland | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

17700

CERTIFICATE OF DEATH

17695

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb Bowie | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS 2404 Keyberry Lane | |
| 3. NAME OF DECEASED (Type or print) Richard E. Pranschke | | 4. DATE OF DEATH Month Dec. Day 10 Year 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept 26, 1928 |
| 9. AGE (In years last birthday) 38 yrs | | 10. IF UNDER 1 YEAR: Months 12 Days 10 Hours 66 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President | | 10b. KIND OF BUSINESS OR INDUSTRY Bank | |
| 11. BIRTHPLACE (County & State, or foreign country) Indiana | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Gustav E. Pranschke | | 14. MOTHER'S MAIDEN NAME Emma A. Mentzel | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean | | 16. SOCIAL SECURITY NO. 579 34 2780 | |
| 17. INFORMANT Charlotte D. Pranschke | | Address Same as #2 (wife) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sub - Cerebral Hemorrhage 540X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 12-1-66 to 12-10-66 | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct , 19 61 , to Dec , 19 66 that (I) (we) last saw the deceased alive on Dec 10 , 19 66 and that death occurred at 2:35PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Aaron Deftz | | 22b. DATE SIGNED Dec 10, 1966. | |
| 22c. PHYSICIAN'S NAME (Type) Aaron Deftz | | 22d. ADDRESS Pro Geo Plaza Hyattsville, Md. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 14, 1966 | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | 23d. LOCATION (City or Town) (County) (State) Arlington Virginia |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md | | 25a. REC'D BY REGISTRAR DEC 10 1966 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17701

CERTIFICATE OF DEATH

17696

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Calvert | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 10 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS Box 193, Davis Road | |
| 3 NAME OF DECEASED (Type or print) First James Middle R. Last Proctor | | 4. DATE OF DEATH Month December Day 16 , Year 1966 | |
| 5 SEX Male | 6 COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/4/92 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 74 yrs |
| 11 BIRTHPLACE (County & State, or foreign country) Charles County | | 12 CITIZEN OF WHAT COUNTRY? | |
| 13 FATHER'S NAME James Proctor | | 14 MOTHER'S MAIDEN NAME Mary V. Proctor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. 2-13-16-2842A | |
| 17 INFORMANT Charlotte Proctor | | Address Box 123, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO An embolic Coronary Heart Attack Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO Hypertension (c) Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH 1 day 3 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Sept. 12, 1966 , to Dec. 16, 1966 , that (I) (we) last saw the deceased alive on 12-15-1966 , and that death occurred at 2:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE O. Sahakyan | | 22b. DATE SIGNED 12/16/66 | |
| 22c. PHYSICIAN'S NAME (Type) Ohannes Sahakyan, M.D. | | 22d. ADDRESS 5813 Landover Rd., Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-20-66 | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph Catholic Church | 23d. LOCATION (City or Town) (County) (State) Pomfret, Chas. Md. |
| 24. FUNERAL DIRECTOR Marcell Adams Aguiar, Md. | | 25a. REC'D BY REGISTRAR DEC 23 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE James Judge | |

Handwritten notes or markings in the top right corner.



17702

CERTIFICATE OF DEATH

17697

| | | | |
|--|--------------------------|---|--|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a STATE Maryland b. COUNT Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | |
| c LENGTH OF STAY IN lb 21 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d STREET ADDRESS 5218 58th Ave. | |
| 3. NAME OF DECEASED (Type or print) First Albert Middle H. Last Radisch | | 4 DATE OF DEATH Month December Day 28 Year 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9/10/22 2/13 52 53 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postal Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office | |
| 11 BIRTHPLACE (County & State or foreign country) Brentwood, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Herman A. Radisch | | 14. MOTHER'S MAIDEN NAME Evelyn Bless | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) Yes WWII | | 16 SOCIAL SECURITY NO 579-10-1635 | |
| 17 INFORMANT Virginia Radisch | | Address 5218 58th Avenue Riverdale, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. 200.1 IMMEDIATE CAUSE (a) <u>Lymphosarcoma Generalized</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1965 | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-3, 1965, to 12-28, 1966, that (I) (we) last saw the deceased alive on 12-28, 1966, and that death occurred at 9:45 M, from causes and on the date stated above. | | | |
| 22a SIGNATURE George J. Hageage | | 22b. DATE SIGNED AM 12-28-66 | |
| 22c PHYSICIAN'S NAME (Type) George J. Hageage, M.D. | | 22d. ADDRESS 3717 38th Ave., Cottage City, Md. | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 31, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE Silver Spring, Md. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. This page should be removed from the certificate and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17703

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17698

| | | | | | |
|--|---------------------------|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glenn Dale c. LENGTH OF STAY IN 1b five days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10041 Locust Street | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Kentucky b. COUNTY Union c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sturgis d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Tenrie Bernice Reed | | | 4. DATE OF DEATH Month Day Year 12 16 1966 | | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Nov 1, 1906 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Month Days Hours Min. IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | | 11. BIRTHPLACE (State or foreign country) Kentucky | |
| 13. FATHER'S NAME - Clark | | | 14. MOTHER'S MAIDEN NAME Rhoda - | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Roy Lee Reed Sturgis Kentucky Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes five years |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D., Riverdale, Maryland | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED 12-17-66 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 21, 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Pythian Ridge Cemetery | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

17704

CERTIFICATE OF DEATH

17700

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | c. LENGTH OF STAY IN IB 2 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hysttsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 8311 Allendale Drive | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED (Type or print) First Baby Middle Girl Last Remick | | 4 DATE OF DEATH Month December Day 17 Year 19 66 | |
| 5 SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 12/15/66 |
| 9. AGE (In years last birthday) yrs 2 Months 2 Days 2 Hours Min | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Prince George's, Maryland U.S. A. | |
| 12 CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Richard Joseph Remick | |
| 14. MOTHER'S MAIDEN NAME Judith Lee Brutsche | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Father Address As above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) prematurity DUE TO 1100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 19 66 to Dec. 17, 19 66 , that (I) (we) last saw the deceased alive on Dec. 17, 19 66 and that death occurred at 12:50 PM from causes and on the date stated above. | | | |
| 22a. SIGNATURE Andrew G. Aronoff M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED Dec 18, 1966 |
| 22c. PHYSICIAN'S NAME (Type) Andrew G. Aronoff M.D. | | 22d. ADDRESS 6803 Good Luck Road, Lanham, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 12/24/66 | 23c. NAME OF CEMETERY OR CREMATORY Prince Georges Gen. Hosp | 23d. LOCATION (City or Town) (County) (State) Cheverly, Prince Georges, Maryland |
| 24 FUNERAL DIRECTOR Harvey W. Penn, Jr., Admin., Cheverly, Maryland | | 25a. EXAMINED BY REGISTRAR DEC 23 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

MARYLAND STATE

17705

CERTIFICATE OF DEATH

17701

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 8 days | | 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d. STREET ADDRESS 3414 Newton Street | |
| 3. NAME OF DECEASED (Type or print) First Ruth Middle E Last Richards | | 4. DATE OF DEATH Month Dec Day 3 Year 19 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 17 June 1898 |
| 9. AGE (In years last birthday) 68 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 19 Hours 66 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Nurse | |
| 11. BIRTHPLACE (County & State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Charles Kendall | | 14. MOTHER'S MAIDEN NAME Nellie Carter | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Charles T. Richards | | Address Same as Item #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 577X IMMEDIATE CAUSE (a) Shock DUE TO (b) Gangrene of ileum DUE TO (c) Adhesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration pneumonia, acidosis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11/21 , 19 66 , to 12/3 , 19 66 , that (I) (we) lost saw the deceased alive on 12/3 , 19 66 , and that death occurred at 1:45 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE John H. Bayly | | 22b. DATE SIGNED 12/3/66 | |
| 22c. PHYSICIAN'S NAME (Type) JOHN H. BAYLY | | 22d. ADDRESS 1835 EYE N.W. WASH D. C | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 6-1966 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Suitland Md. |
| 24. FUNERAL DIRECTOR Simmons Bros 1661 Good Hope Rd NE | | 25. REC'D BY REGISTRAR 1966 | |
| 26. REGISTRAR'S SIGNATURE U. [Signature] | | DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17702

| | | | | | | | |
|---|--|---|--|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE District of Columbia b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN lb DOA | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 7 Needles Green, S.W. | | | |
| 3. NAME OF DECEASED (Type or print) Charles E. Richmond | | | | 4. DATE OF DEATH Month 12 Day 10 Year 1966 | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 26 June, 1942 | |
| 9. AGE (in years last birthday) yrs 24 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SERVICE MAN | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY | | 11. BIRTHPLACE (State or foreign country) CALIFORNIA | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME Charles E. Compton | | | |
| 14. MOTHER'S MARDEN NAME Thelma | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES ACTIVE | | | |
| 16. SOC. A. SECURITY NO. 562-54-4988 | | | | 17. INFORMANT MARY V. RICHMOND Address SECT 2 | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade and left hemithorax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Gunshot wound of chest (32 cal.) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Shot self in chest | | | |
| 20c. TIME OF INJURY Month, Day, Year Dec 12 10 19 66 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Picnic area off Queens Chapel Rd nr Hamilton St | |
| 20f. (City or town) Hyattsville | | | | 20g. (County) D.C. | | 20h. (State) MD. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| 22. DATE SIGNED 12-11-66 | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| Address (Street, city, town, or county) | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify) 12/14/66 | | | |
| 23b. DATE THEREOF | | | | 23c. NAME OF CEMETERY OR CREMATORY BARRONCERS MATH. PENSA COLA, F.L.H. | | | |
| 23d. LOCATION (City or Town) WASHINGTON D.C. | | | | 23e. LOCATION (County) DC | | | |
| 23f. LOCATION (State) DC | | | | 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. | | | |
| 25a. REC'D BY REGISTRAR Charles Judge | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| DATE DEC 15 1966 | | | | | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17707

CERTIFICATE OF DEATH

17704

| | | | |
|--|--|--|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb. 13 hrs. 15 min. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 13108 Bellevue Street | |
| 3 NAME OF DECEASED (Type or print) First Baby Middle Boy Last Schmidt | | 4 DATE OF DEATH Month December Day 9 Year 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 8, 1966 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (in years last birthday) yrs 13 Months 15 |
| 11 BIRTHPLACE (County & State, or foreign country) Prince Geo., Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Armand Schmidt | | 14. MOTHER'S MAIDEN NAME Eloise Carolyn Virginia Matthews | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT Mother Address As above |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 760.0 IMMEDIATE CAUSE (a) Subdural Hematoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from December 8, 1966 , to December 9, 1966 , that (I) (we) last saw the deceased alive on December 9, 1966 and that death occurred at 12:00M , from causes and on the date stated above. | | | |
| 22a. SIGNATURE M. D. Bernardo Alvarado | | 22b. DATE SIGNED 12/12/66 | |
| 22c. PHYSICIAN'S NAME (Type) M. D. Bernardo Alvarado | | 22d. ADDRESS 6201 Riverdale Rd., Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 12/17/66 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Maryland | | 25a. RECD BY REGISTRAR DEC 21 1966 | 25b. REGISTRAR'S SIGNATURE Schm... |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reinterment, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 4 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

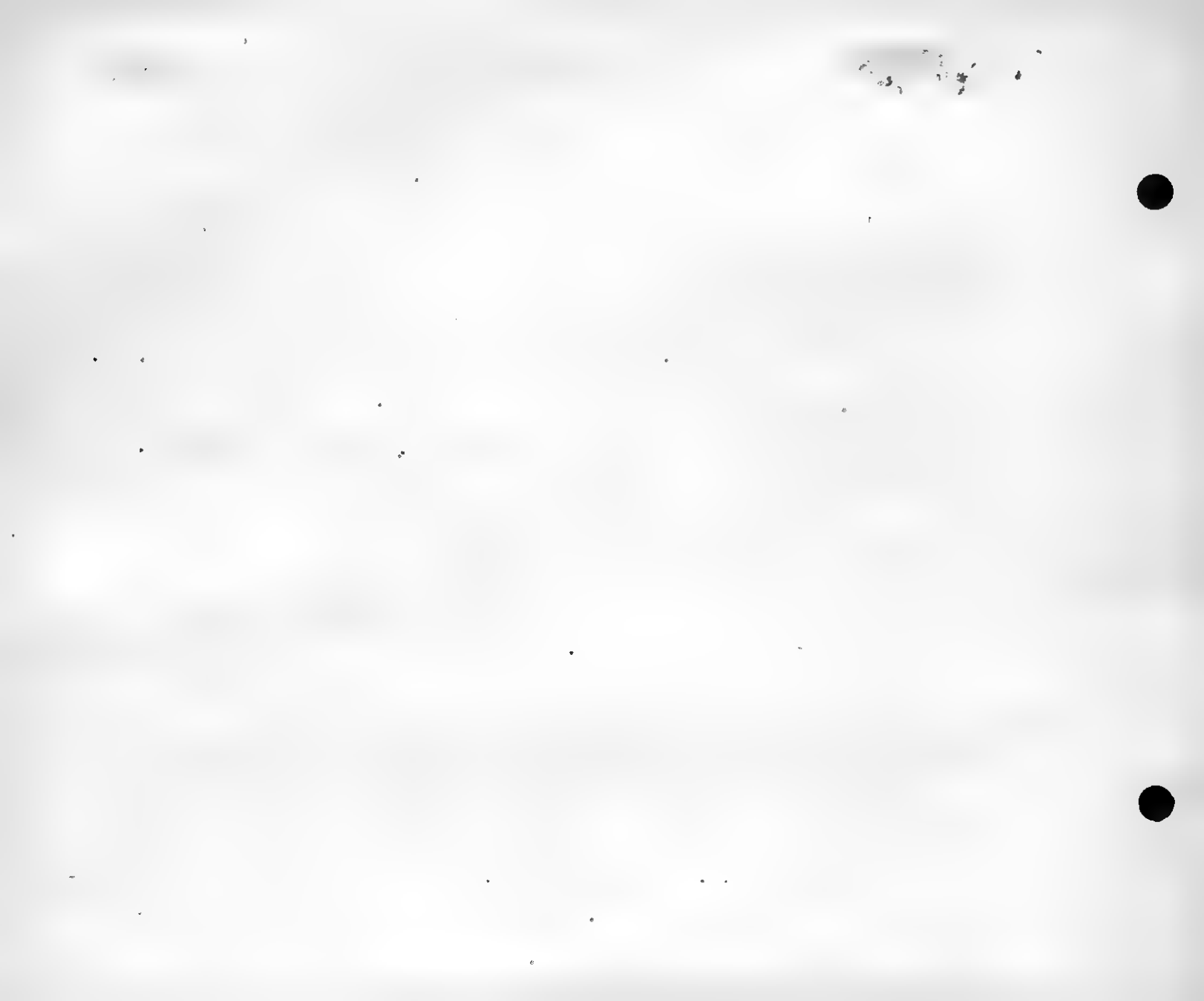
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17708

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17705

| | | | | | |
|--|------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Mt. Rainier | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home | | | d. STREET ADDRESS 2704 Upshur Street, Apt. 5 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last Alyce Rita Schneider | | | 4. DATE OF DEATH Month 12 Day 28 Year 1966 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-7-1905 | | 9. AGE (In years last birthday) 61 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | | 11. BIRTHPLACE (State or foreign country) Pennsylvania | |
| 13. FATHER'S NAME Patrick I. Lyons | | | 14. MOTHER'S MAIDEN NAME Mary A. Sullivan | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO Unknown | | 17. INFORMANT Barbara A. Rayner 8012 Park Lane Bethesda, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes - known over 15 yrs. | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 12-28-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | Address (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/30/66 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | |
| | | 23d. LOCATION (City or town) (County) (State) Washington D.C. | | | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | ADDRESS | | 25a. REC'D BY REG. STRAR DATE JAN 3 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

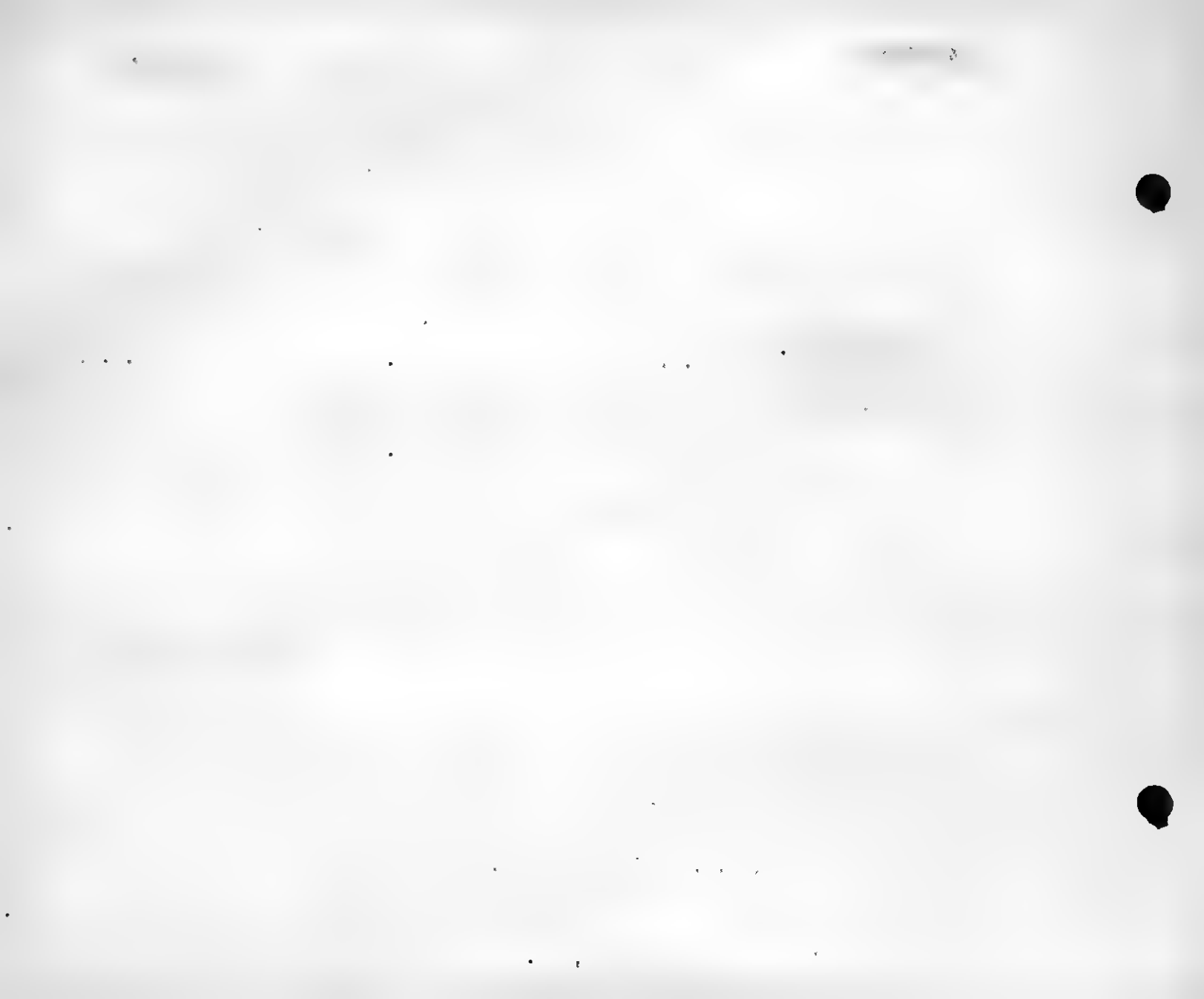
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17709

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17706

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c LENGTH OF STAY IN 1b <u>DOA</u> | | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | d IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | | | d. STREET ADDRESS <u>5608 Gallitan Place</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>M</u> Last <u>Sheehan</u> | | | | 4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1966</u> | | | |
| 5 SEX <u>Male</u> | 6 COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>17 Dec. 1899</u> | 9 AGE (In years last birthday) <u>67</u> Yrs | IF UNDER 1 YEAR Months <u>12</u> Days <u>28</u> Hours <u>19</u> Min <u>66</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 10a. PLACE OF BIRTH <u>Rehoboth Beach, Delaware</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u> | | 11 BIRTHPLACE (State or foreign country) <u>Mass.</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward M. Sheehan</u> | | | | 14 MOTHER'S M maiden NAME <u>Julia Ann Burns</u> | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16 SOCIAL SECURITY NO <u>577 34 6192</u> | | 17. INFORMANT Address <u>Katherine O. Sheehan Same as #2 (wife)</u> | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 5 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) | (County) | (State) | | |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | 22. DATE SIGNED <u>12-28-66</u> | | Address (Street, city, town, or county) | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b DATE THEREOF <u>12/30/66</u> | 23c NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 23d LOCATION (City or Town) | (County) | (State) | <u>Arlington Va.</u> |
| 24 FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u> | | | | 25a REC'D BY REGISTRAR DATE <u>JAN 3 1967</u> | | 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

17710

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 13, 14 Information from birth cert.

CERTIFICATE OF DEATH

17707

| | | | | | |
|--|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 15 hours | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Odenton | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 1610 Annapolis Road | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Baby Girl Shifflett | | 4. DATE OF DEATH Month Day Year December 7 19 66 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/6/66 | | 9. AGE (In years last birthday) yrs. Months Days Hours Min. 15 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Pr. Geo's Co., Md. | |
| 13. FATHER'S NAME Unknown | | | 14. MOTHER'S MAIDEN NAME Mary Ann Shifflett | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 762.5 IMMEDIATE CAUSE (a) Bilateral Atelectasis DUE TO (b) Prematurity (1360 gms.) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS A T.O.P.S.Y. PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/6 , 19 66 , to 12/7 , 19 66 , that (I) (we) last saw the deceased alive on 12/7 , 19 66 , and that death occurred at 10a. M, from causes and on the date stated above | | | | | |
| 22a. SIGNATURE Dr. Van Gelderen | | 22b. DATE SIGNED 12/7/66 | | 22c. PHYSICIAN'S NAME (Type) Dr. Van Gelderen | |
| 22d. ADDRESS 3001 Cheverly Ave., Cheverly Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 12/17/66 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hosp. | 23d. LOCATION (City or Town) (County) (State) Cheverly PG Maryland | | |
| 24. FUNERAL DIRECTOR Harry W. Penn, Jr., Admin., Cheverly, Md. | | 25a. RECEIVED BY REGISTRAR DEC 21 1966 | | 25b. REGISTRAR'S SIGNATURE 2 | |



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 2 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17711

| | | | | | | | |
|--|----------------------------------|---|---|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. LENGTH OF STAY IN lb DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill | | 16. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chamber's Funeral Home | | | | d. STREET ADDRESS 6717 Rock Road | | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Bernard Augusta Simms | | | | 4. DATE OF DEATH Month Day Year 12 1 19 66 | | | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 16 July-1938 | | 9. AGE (in years last birthday) 28 Yrs | | IF UNDER 1 YEAR Months Days Hours Min 19 66 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Augustus G. Thompson | | | | 14. MOTHER'S MAIDEN NAME Margaret Simms | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 492X IMMEDIATE CAUSE (a) Aspiration of gastric contents DUE TO (b) Bilateral pneumonitis DUE TO (c) lost Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Minutes Days |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | | Address (Street, city, town, or county) 17-3-66 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/8/66 | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul Methodist Church Cemetery | | 23d. LOCATION (City or Town) (County) (State) Oxon Hill, Md. | |
| 24. FUNERAL DIRECTOR Robert G. Mason Funeral Home, Inc. 2900 Nichols Avenue, S.E., Washington 20, D. C. | | | | 25a. REC'D BY REGISTRAR DATE DEC 8 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

17712

CERTIFICATE OF DEATH

17709

| | | | |
|--|---|--|---|
| 1 PLACE OF DEATH a COUNTY PRINCE GEORGE MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE VIRGINIA b COUNTY FAIRFAX | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE | | c LENGTH OF STAY IN 1b DOA | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF HOSPITAL ANDREWS, ANDREWS AFB | | e STREET ADDRESS 6326 BERYL ROAD | |
| 3 NAME OF DECEASED (Type or print) Bessie First Middle Last BESSICA V SMITH | | 4 DATE OF DEATH Month DECEMBER Day 27 Year 19 66 | |
| 5 SEX FEMALE | 6 COLOR OR RACE CAU | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 18 DEC 1917 |
| 9 AGE (in years last birthday) 49 yrs | | 10 UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) HOUSEWIFE | | 10b KIND OF BUSINESS OR INDUSTRY n/a | |
| 11 BIRTHPLACE (County & State, or foreign country) MISSOURI | | 12 CITIZEN OF WHAT COUNTRY? U.S. | |
| 13 FATHER'S NAME CHARLES EUGENE CHAMBERLIN | | 14 MOTHER'S MAIDEN NAME NOT KNOWN | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 577 30-2908 | |
| 17 INFORMANT HUSBAND | | Address SAME AS # 2 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMORRHAGE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) LIVER DISEASE DUE TO (c) POSSIBLE ALCOHOLISM | | | INTERVAL BETWEEN ONSET AND DEATH minutes Years Years |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 10 (this hospital) attended the deceased from 23 JUNE , 19 65 , to 27 DEC , 19 66 , that 10 (we) lost saw the deceased alive on 23 NOVEMBER , 19 66 , and that death occurred at 5:15 AM from causes and on the date stated above. | | | |
| 22a. SIGNATURE David S. Teperson M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED 27 DEC 66 |
| 22c. PHYSICIAN'S NAME (Type) DAVID S. TEPERSON | | 22d. ADDRESS USAF HOSPITAL ANDREWS ANDREWS AFB, WASH., D.C. 20331 | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) Burial | 23b. DATE THEREOF 12-30-66 | 23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL | 23d. LOCATION (City or town) (County) (State) ARLINGTON VIRGINIA |
| 24 FUNERAL DIRECTOR W W CHAMBERS Co - 3072 W ST N W WASH. D.C. | | 25a. REC'D BY REGISTRAR DEC 30 1966 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

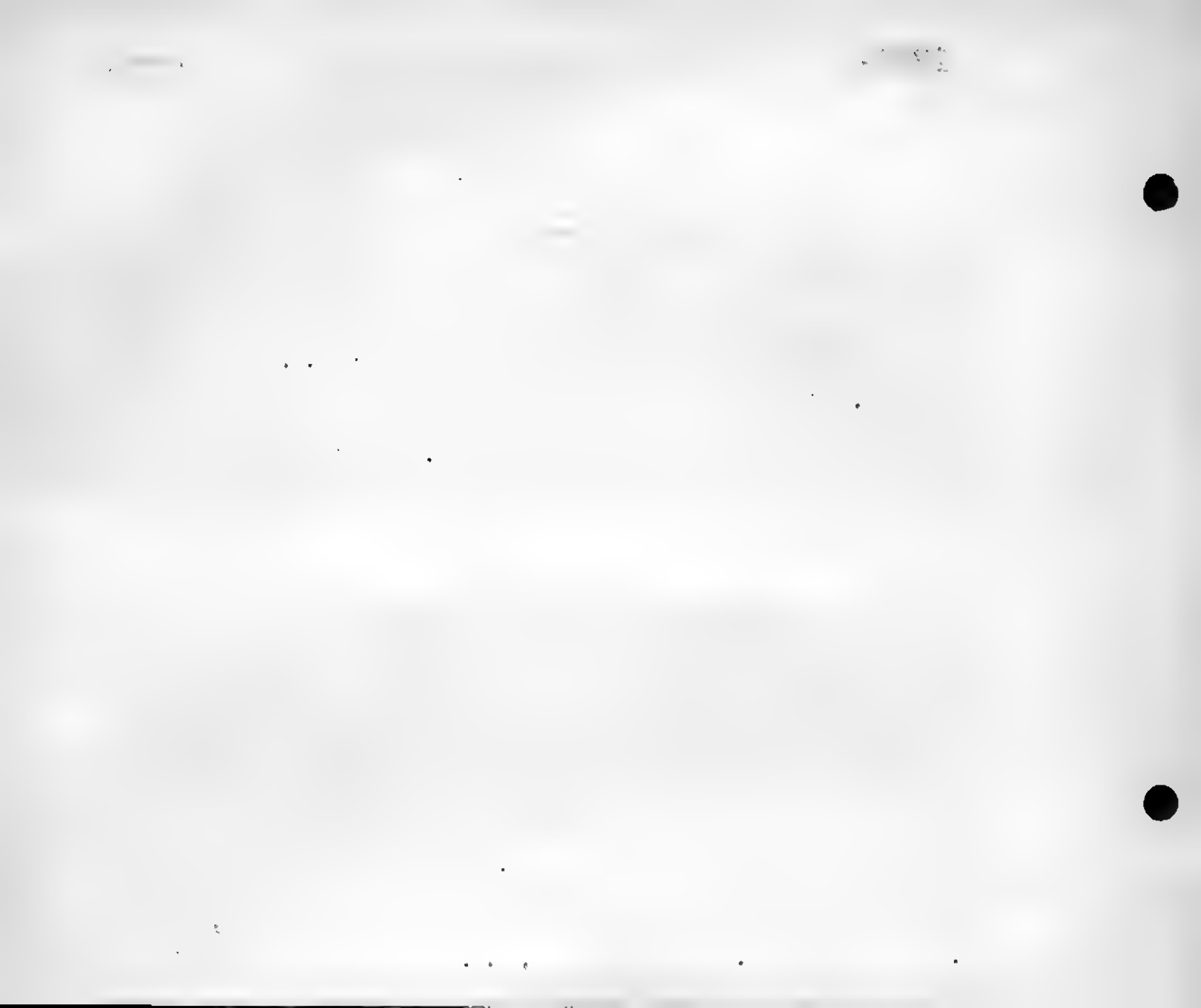
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17713

Item 9 Film 3384 12/12/66
Item 8 Film 3384 12/22/66
MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17710

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb DOA | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland | | b. COUNTY Prince George's | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arden Woods | | d. STREET ADDRESS 7920 Echols Avenue | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) James William Smith | | 4 DATE OF DEATH 12 2 19 66 | | 5 SEX Male | | 6 COLOR OR RACE Negro | | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8 DATE OF BIRTH 28 Dec. 1924 | | 9 AGE (In years) 41 1/2 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Government employee | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (State or foreign country) Washington, D.C. | |
| 12 CITIZEN OF WHAT COUNTRY? USA | | 13 FATHER'S NAME James E. Smith | | 14. MOTHER'S MAIDEN NAME Mary Morton | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes World War II | | 16 SOCIAL SECURITY NO. | |
| 17 INFORMANT Marzel G. Smith 7920 Echols Avenue | | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pneumonitis 492X DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | | 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | 22. DATE SIGNED 12-2-66 | |
| ACTUAL SIGNATURE John Echols, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/6/1966 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | | 25a. REC'D BY REGISTRAR DATE DEC 7 1966 | |
| 24. FUNERAL DIRECTOR W. Ernest Jarvis Co., 1132 You Street, N.W., Washington, D.C. | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | 25c. REGISTRAR'S NAME Charles Judge | | 25d. REGISTRAR'S ADDRESS 1132 You Street, N.W., Washington, D.C. | | 25e. REGISTRAR'S PHONE NO. | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66
Jwb

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17714

CERTIFICATE OF DEATH

17711

| | | | |
|--|------------------------------------|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Memorial Hospital | | d. STREET ADDRESS 5003 37th. Pl., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Alice Lee Souder | | 4 DATE OF DEATH Month Day Year 12-29-66 19 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 2-2-11 |
| 9 AGE (In years, last birthday) 55 yrs | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Own Home |
| 11 BIRTHPLACE (County & State, or foreign country) W. Virginia | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John David Sears | | 14. MOTHER'S MAIDEN NAME Lula Lewis | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. Unk. | |
| 17. INFORMANT Deyerle B. Souder Address (Same as # 2) Medical Record and Husband | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 6 DAYS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12-23-66 , 19, to 12-29-66 , that (I) (we) lost saw the deceased alive on 12-29 19 66 , and that death occurred at 3:50 P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE C. J. Houmann | | 22b. DATE SIGNED 12-29-66 | |
| 22c. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D. | | 22d. ADDRESS 4404 Queensbury Rd., Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1/1/66 | 23c. NAME OF CEMETERY OR CREMATORY Beaver Run Cemetery | 23d. LOCATION (City or Town) (County) (State) Keyser W. Va. |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| ADDRESS Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17715

CERTIFICATE OF DEATH

17712

| | | | |
|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Pro Georges | |
| b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Riverdale | | c LENGTH OF STAY IN 1b D O A | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Leland Memorial Hospital | | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Norval H Spicknall | | 4 DATE OF DEATH Month Day Year Dec 21, 1966 19 | |
| 5. SEX male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH Aug 9, 1906 |
| 9. AGE (in years last birthday) yrs 60 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bio Chemist | |
| 10b. KIND OF BUSINESS OR INDUSTRY Dept of Agriculture | | 11. BIRTHPLACE (County & State, or foreign country) Pro Geo Co. Md. | |
| 12 CITIZEN OF WHAT COUNTRY? U S A | | 13. FATHER'S NAME Norval H Spicknall sr | |
| 14 MOTHER'S MAIDEN NAME Hester Jones | | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -- | |
| 16 SOCIAL SECURITY NO 217 44 0512 | | 17. INFORMANT Address Stella P Spicknall Beltsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 4:50/ IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <i>Acute Coronary Thrombosis</i> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 9-1, 1950, to 12-21, 1966, that (I) (we) last saw the deceased alive on 12-21, 1966, and that death occurred at 4:21 PM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>A. Deitz</i> | | 22b. DATE SIGNED 12-21-66 | |
| 22c. PHYSICIAN'S NAME (Type) A Deitz | | 22d. ADDRESS Pro Geo Plaza Hyattsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec 23, 1966 | 23c. NAME OF CEMETERY OR CHURCH St Johns Episcopal | 23d. LOCATION (City or town) (County) (State) Beltsville Pro Geo Md. |
| 24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE 12-21-66 | |
| | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please detach the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

17716

CERTIFICATE OF DEATH

17713

| | | | |
|--|--------------------------|---|------------------------------|
| 1 PLACE OF DEATH a COUNTY Prince Geo. MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Pr. Geo. | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier | | c LENGTH OF STAY IN 1b 6 yrs. | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4200 - 31st St. | | d STREET ADDRESS 4200 - 31st St. | |
| e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Mary M. Spilman | | 4 DATE OF DEATH Month Day Year Dec. 29 1966 | |
| 5 SEX Female | 6 COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2/4/1910 |
| 9 AGE (In years last birthday) 56 yrs. | | 10 IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tele. Operator | | 10b KIND OF BUSINESS OR INDUSTRY Gramercy Inn | |
| 11 BIRTHPLACE (County & State, or foreign country) New York City | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Porterfield | | 14. MOTHER'S MAIDEN NAME Mary E. Bell | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. Robert M. Spilman (above address) (Husband) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Supper not eaten - 1 hr | | INTERVAL BETWEEN ONSET AND DEATH 1 hr | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac - 2 hr | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 1959, 19 to 1966, that (I) (we) last saw the deceased alive on 12/23/66 and that death occurred on 12/29/66, from causes and on the date stated above. | | | |
| 22a SIGNATURE G. M. Jones | | 22b DATE SIGNED 12/30/66 | |
| 22c PHYSICIAN'S NAME (Type) G. M. Jones | | 22d ADDRESS 4400 - Stamp Rd., Temple Hills, Md. | |
| 23a BURIAL, CREMATION, REMOVAL Burial | | 23b. DATE THEREOF 12/31/66 | |
| 23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem. | | 23d LOCATION (City or Town) (County) (State) Colmar Manor, Md. | |
| 24 FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | 25a REC'D BY REGISTRAR DATE JAN 9 1967 | |
| 25b. REGISTRAR'S SIGNATURE G. M. Jones | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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17717

CERTIFICATE OF DEATH

17714

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY in ib | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Prince George General Hospital | | d. STREET ADDRESS 5400--You St., SE | |
| 3. NAME OF DECEASED (Type or print) ESTELLE L. STONE | | 4. DATE OF DEATH Month Dec. Day 14th Year 1966 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH July 29th, 1912 |
| 9. AGE (In years last birthday) 54 yrs. | | 10. IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min 14 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY G. S. A. | |
| 11. BIRTHPLACE (County & State, or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME William Suthard | | 14. MOTHER'S MAIDEN NAME Lula Wright | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Margaret L. Foley-1905-54th Ave., SE | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Hypertension and DUE TO (c) mitral arteriosclerosis | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1/2 , 19 63 to 12-12 , 19 66 that (I) (we) last saw the deceased alive on 12-12 19 66 and that death occurred at 5:15 P.M. from causes on and on the date stated above. | | | |
| 22a. SIGNATURE Arthur T. Jones M.D. | | 22b. DATE SIGNED Dec. 15th 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Arthur T. Jones | | 22d. ADDRESS 4601-Nichols Ave., SW Wash. DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF Dec. 17-1966 | 23c. NAME OF CEMETERY OR CREMATORY Washington Natl. | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland |
| 24. FUNERAL DIRECTOR Simmons Bros. 1661-Good Hope Rd SE Wash DC | | 25a. REC'D BY REGISTRAR DATE: 12-13-1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

17718

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

17715

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | c. LENGTH OF STAY IN 1b 11 days | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland | | b. COUNTY P.G. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General | | | | e. STREET ADDRESS 4114 31st. Street | | | | f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Marybeth C. Stretmater | | 4. DATE OF DEATH 12 -30-66 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 5-11-21 | | 9. AGE (In years last birthday) 45 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk | | 10b. KIND OF BUSINESS OR INDUSTRY U. S. Govt. | | 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. | |
| 12. CIT ZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME Clifford M. Stretmater | | 14. MOTHER'S MAIDEN NAME Nettie Callan | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. yes | |
| 17. INFORMANT Helen M. Beers | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO upper gastro-intestinal bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced cirrhosis of the liver DUE TO (c) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | | Address 9005 Kirkdale Rd. Bethesda, Md. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (H) (this hospital) attended the deceased from Dec. 19, 1966 , to Dec. 30, 1966 that (H) (we) last saw the deceased alive on Dec. 30, 1966 , and that death occurred at 8:35 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Ky Choi | | 22b. DATE SIGNED 12-31-66 | | 22c. PHYSICIAN'S NAME (Type) Ky Choi | | 22d. ADDRESS Prince Geo. Gen. Hospital, Cheverly, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Jan. 3, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington, D. C. | | | |
| 24. FUNERAL DIRECTOR John B. Thomas | | 25a. REC'D BY REGISTRAR JAN 6 1967 | | 25b. REGISTRAR'S SIGNATURE John B. Thomas | | 25c. ADDRESS 8434 Georgia Ave. Silver Spring, Md. | | | |

FOR STATE
HEALTH DEPT.

17719

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17716

| | | | |
|--|--------------------------|--|--|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b DOA | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d STREET ADDRESS 5603 Chillum Heights Drive | |
| 3. NAME OF DECEASED (Type or print) First Wesley Middle Clark Last Swim | | 4. DATE OF DEATH Month 12 Day 27 Year 1966 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 7-27-1939 |
| 9 AGE (in years last birthday) 27 yrs | | 10 UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC | | 10b KIND OF BUSINESS OR INDUSTRY TOLEDO SCALE CO | |
| 11 BIRTHPLACE (State or foreign country) CANADA | | 12 CITIZEN OF WHAT COUNTRY? CANADA | |
| 13. FATHER'S NAME HAROLD SWIM | | 14 MOTHER'S MAIDEN NAME EDITH THOMAS | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES | | 16 SOCIAL SECURITY NO 578 52 02 81 | |
| 17 INFORMANT ANNA F. SWIM | | Address SAME AS #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item B.) Drowned when boat capsized. | |
| 20c. TIME OF INJURY Month, Day, Year Hour or min 3:30pm 12-26-1966 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Potomac River Cove | | 20f. (City or town) (County) (State) 1 mile so. of Wilson Br. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 12-28-66 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | Address (Street, city, town, or county) Riverdale, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 12-30-1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN | | 23d. LOCATION (City or town) (County) (State) BLADENSBURG, MARYLAND | |
| 24 FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Maryland | | 25a. REC'D BY REG STRAR DATE JAN 3 1967 | |
| 25b. REG STRAR'S SIGNATURE Charles Judge | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

17720

CERTIFICATE OF DEATH

17717

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb 3 wks. 4 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Hts. | | d. STREET ADDRESS 2600 Easton Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Adele Lizzie Taylor | | 4. DATE OF DEATH Dec. 24 19 66 | |
| 5. SEX Fem. | 6. COLOR OR RACE Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-6-1903 |
| 9. AGE (In years last birthday) 63 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) House Wife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (County & State, or foreign country) S. C. | | 12. CITIZEN OF WHAT COUNTRY? A. | |
| 13. FATHER'S NAME William A. Gray | | 14. MOTHER'S MAIDEN NAME Jessie Massey | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO Unk. | |
| 17. INFORMANT Nellie G. Foley | | Address Same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 174X IMMEDIATE CAUSE (a) cardio-respiratory arrest DUE TO disseminated cancer Conditions, if any, which gave rise to immediate cause (b) uterine cancer stating the underlying cause lost. (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 11-29 , 19 66 , to 12-24 19 66 , that (I) (we) last saw the deceased alive on 12 19 66 and that death occurred at 8:15 P M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE K. Y. Choi | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) Ky Choi | | 22d. ADDRESS Pr. Geo. Gen. Hosp., Cheverly, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/28/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery | | 23d. LOCATION (City or Town) (County) (State) Westminster S. C. | |
| 24. FUNERAL DIRECTOR J. L. Smith Sons, Bay Mills, Md. | | 25a. REC'D BY REGISTRAR DEC 29 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |



TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed on 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in. The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| - DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 17721 | | | | | | 17718 | | | | | |
| 1. PLACE OF DEATH | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | | |
| a. COUNTY Prince Georges | | | | | | b. COUNTY Arlington | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | | | |
| CHEVERLY | | | | | | Arlington | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | | | | | d. STREET ADDRESS | | | | | |
| Prince Georges County Hospital | | | | | | 1201 N. Kensington Street | | | | | |
| 3. NAME OF DECEASED (Type or print) | | | | | | 4. DATE OF DEATH | | | | | |
| First Middle Last Annie E. Tegeder | | | | | | Month Day Year December 31 19 66 | | | | | |
| 5. SEX | | | | | | 6. COLOR OR RACE | | | | | |
| Female | | | | | | White | | | | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | | | | | 8. DATE OF BIRTH | | | | | |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | May 28, 1889 | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Housewife | | | | | | Home | | | | | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME | | | | | |
| James L. Floyd | | | | | | Annie L. | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO | | | | | |
| | | | | | | | | | | | |
| 17. INFORMANT | | | | | | Address | | | | | |
| Anna H. Whitehead (Daughter) | | | | | | 2604 N. 12th St., Arlington, Virginia | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | | | | | | | | | | | |
| 422.1 DUE TO Congestive Heart Failure | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| arteriosclerotic Cardio-Vascular Disease | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURED [Enter nature of injury in Part I or Part II of item 18.] | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year | | | | | | | | | | | |
| Hour a.m. p.m. 19 | | | | | | | | | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | |
| 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Dec. 27, 1966 to Dec. 31, 1966 that (I) (we) last saw the deceased alive on Dec. 31, 1966 , and that death occurred at 12:47 A.M. from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE | | | | | | | | | | | |
| William Brainin M.D. | | | | | | | | | | | |
| 22b. DATE SIGNED 1/31/67 | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) WM BRAININ | | | | | | | | | | | |
| 22d. ADDRESS 6124 Central Ave, Capitol Heights Md | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | |
| Burial | | | | | | | | | | | |
| 23b. DATE THEREOF Jan. 4, 1967 | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens | | | | | | | | | | | |
| 23d. LOCATION (City, town or county) (State) Arlington, Virginia | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE | | | | | | | | | | | |
| IVES FUNERAL HOME 2847 Wilson Blvd. Arlington, Virginia | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR | | | | | | | | | | | |
| DATE JAN 5 1967 | | | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE J. J. Judge | | | | | | | | | | | |

17722

CERTIFICATE OF DEATH

17719

| | | | |
|--|-----------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince Georges | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural) | | c LENGTH OF STAY IN 1b 3 yrs. 2 wks | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital | | d STREET ADDRESS 4319 Van Buren St. | |
| 3 NAME OF DECEASED (Type or print) First Josephine Middle E. Last Thatcher | | 4 DATE OF DEATH Month 12 Day 20 Year 19 66 | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH 5/21/02 |
| 9 AGE (In years last birthday) 64 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Computer | | 10b. KIND OF BUSINESS OR INDUSTRY Last employed at -- Dept. of Army | |
| 11 BIRTHPLACE (County & State, or foreign country) Washington, D. C. | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas A. Connors | | 14. MOTHER'S MAIDEN NAME Sarah McGinley | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 577-20-5369 | |
| 17. INFORMANT Decedent | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent bronchopneumonia, bilateral DUE TO (b) _____ DUE TO (c) cirrhosis of the liver with liver failure | | | |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) unknown | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (A) (this hospital) attended the deceased from 12/6/1963 , to 12/20/1966 , that (B) (we) last saw the deceased alive on 12/20/1966 , and that death occurred at 4:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <i>Moe Weiss</i> | | 22b. DATE SIGNED 12/20/66 | |
| 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D. | | 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md. | |
| 23a. FUNERAL CREMATION, REMOVAL (Specify) 12/22/66 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet | | 23d. LOCATION (City or town) (County) (State) Washington, D.C. | |
| 24. FUNERAL DIRECTOR <i>Francis J. Collins</i> | | 25a. REC'D BY REGISTRAR DEC 27 1966 | |
| 25b. REGISTRAR'S SIGNATURE <i>Francis J. Collins</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17723

17720

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN lb DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chapel Oaks | | d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | | d. STREET ADDRESS 1105 57th. Avenue | | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Melvin Thomas | | | | 4 DATE OF DEATH Month Day Year 12 27 1966 | | | |
| 5 SEX Male | | 6 COLOR OR RACE Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH 8 Oct. 1953 | |
| 9 AGE (In years lost birthday) 13 yrs | | IF UNDER 1 YEAR Months Days Hours Min | | 11 BIRTHPLACE (State or foreign country) Waynesboro, Ga | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13 FATHER'S NAME Thompson C. Thomas | | | | 14 MOTHER'S MAIDEN NAME Louise Thomas (Singleton) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) | | | | 16 SOCIAL SECURITY NO | | 17 INFORMANT Address Thompson C. Thomas Chapel Oak, Md. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Status asthmaticus DUE TO Bronchial asthma (b) _____ DUE TO _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH hours over 10 yrs |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) | | 20f (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kohoe, M.D. Riverdale, Md. | | | | 22. DATE SIGNED 12-28-66 | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b DATE THEREOF 12/31/66 | | 23c NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d LOCATION (City or Town) (County) (State) Landover Md. | |
| 24 FUNERAL DIRECTOR R.N. Horton Company | | | | ADDRESS 1324 You St. N.W. | | 25b REGISTRAR'S SIGNATURE DATE JAN 3 1967 | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17724

CERTIFICATE OF DEATH

17721

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--|--|--|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY in 1b 5 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Home | | | | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Charlotte Hall <i>0532</i> d. STREET ADDRESS R.R.# 1, e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 3 NAME OF DECEASED (Type or print) First Madeline Middle Carmel Last Tippett | | | | 4 DATE OF DEATH Month December Day 5 Year 19 66 | | | | | |
| 5 SEX Female | | 6 COLOR OR RACE White | | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8 DATE OF BIRTH Aug. 27, 1895 | | 9 AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Newport, Maryland | | 12 CITIZEN OF WHAT COUNTRY? United States | |
| 13 FATHER'S NAME William Edward Simpson | | | | 14. MOTHER'S MAIDEN NAME Lillian F. Edwards | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | | | 16 SOCIAL SECURITY NO 578-18-8688 | | 17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ADENOCARCINOMA OF RECTUM DUE TO C METASTASES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HTA DUE TO (c) | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 1</u> , 19 <u>66</u> , to <u>DEC 5</u> , 19 <u>66</u> that (I) (we) lost saw the deceased alive on <u>DEC 3</u> , 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <i>Thomas F. Collins</i> | | | | | | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) THOMAS F. COLLINS MD | | | | | | | | 22d. ADDRESS 322- H STINE | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 12/9/66 | | 23c. NAME OF CEMETERY OR CREMATORY St. Mary's | | 23d. LOCATION (City or Town) (County) (State) Newport, Charles Md | |
| 24 FUNERAL DIRECTOR ARCHART FUNERAL HOME INC. | | | | ADDRESS LA PLATA, MD. | | 25a. REC'D BY REGISTRAR DEC 12 1966 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17725

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17722

| | | | |
|---|--|---|--|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u> | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | c. LENGTH OF STAY (In ib) <u>45 minutes</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George General Hospital</u> | | d. STREET ADDRESS <u>5426 85th. Avenue, Apt. 201</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>Townsend</u> | | 4. DATE OF DEATH Month <u>12</u> Day <u>13</u> Year <u>19 66</u> | |
| 5 SEX <u>Male</u> | 6. CO. OR OR RACE <u>White</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>21 Feb. 1926</u> |
| 9 AGE (In years last birthday) <u>40</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Land Co</u> | | 11 BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | |
| 13 FATHER'S NAME <u>John Michael Townsend</u> | | 14 MOTHER'S MAIDEN NAME <u>Olive Clary</u> | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>Korean</u> | | 16 SOC. A. SECURITY NO. <u>030 18 1026</u> | |
| 17 INFORMANT <u>Marie B Townsend</u> | | Address <u>Lanham, Md.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO <u>from fracture of skull</u> (b) <u>From trauma - auto accident</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Driver of car involved in a collision</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>10:50 p.m.</u> <u>12-13-19 66</u> | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <u>St. Rt. 3, 300ft north of Rt. 50, Prince George</u> | 20f. (City or town) (County) (State) <u>County, Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <u>Natural causes</u> <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , <u>Suicide</u> <input type="checkbox"/> , <u>Homicide</u> <input type="checkbox"/> , <u>Undetermined manner</u> <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>12-14-66</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec 16, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u> |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | ADDRESS <u>Hyattsville, Md.</u> | |
| 25a. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File request and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

17726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17723

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oheverly c. LENGTH OF STAY in b 2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George Hospital | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Forestville d. STREET ADDRESS 7420 Marlboro Pike e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) Eva s. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 4 DATE OF DEATH 12 Month 9 Day 66 Year 8. DATE OF BIRTH 28 Aug 1898 9. AGE (In years last birthday) 68 yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME 11. BIRTHPLACE (State or foreign country) NEW YORK 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME UNKNOWN | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO - | |
| 17. INFORMANT Emilie Mae Rezenigraus - MD. Address MITCHELL LICK | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Unknown | | INTERVAL BETWEEN ONSET AND DEATH Minutes Unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md. | | 22. DATE SIGNED 12-11-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION | | 23b. DATE THEREOF 12/12/66 | |
| 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY | | 23d. LOCATION (City or Town) (County) (State) SELTANE, MD. | |
| 24. FUNERAL DIRECTOR HITCHCOCK BROS - LIPPER MARLBOROUGH, MD. | | 25a. REC'D BY REGISTRAR DEC 15 1966 DATE | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17727

CERTIFICATE OF DEATH

17724

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Pro Georgia</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherbury</u> | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u> | | d. STREET ADDRESS <u>22 woodland way</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ALVIN</u> Middle <u>H.</u> Last <u>TUCKER SR</u> | | 4. DATE OF DEATH Month <u>Dec</u> Day <u>10</u> Year <u>1966</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Mar 25 - 1908</u> |
| 9. AGE (In years last birthday) <u>58</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maître Le Note</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Christian</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Sellers</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u> | | 16. SOCIAL SECURITY NO. <u> </u> | |
| 17. INFORMANT <u>Lila A. Tucker</u> | | Address <u>Greenbelt Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial infarction (diaphragmatic)</u> +2.1 DUE TO <u>Severe A.S.H.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hrs</u> <u>6 yrs</u> |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | 20f. (City or town) (County) (State) <u> </u> |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>12-10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> , 19 <u>66</u> , and that death occurred at <u>1:35</u> p.m. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Hans Wodak</u> M.D. | | 22b. DATE SIGNED <u>12-11-1966</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HANS WODAK M.D.</u> | | 22d. ADDRESS <u>GREENBELT, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Dec 14, 1966</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Colman Manor Pro Geo Md</u> |
| 24. FUNERAL DIRECTOR <u>H. Gasch's Sons Hyattsville Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 16 1966</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17728

CERTIFICATE OF DEATH

17725

| | | | | | | | |
|---|----------------------------------|---|--|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly | | | | c. LENGTH OF STAY IN 1b 9 days | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 6424 Old Landover Road | | | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle E. Last Turner | | | | 4. DATE OF DEATH Month December Day 16 , Year 1966 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6/15/88 | 9. AGE (In years last birthday) 78 yrs. | IF UNDER 1 YEAR Months 16 Days 19 | IF UNDER 24 HRS. Hours 66 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lock Smith | | 10b. KIND OF BUSINESS OR INDUSTRY Self | | 11. BIRTHPLACE (County & State, or foreign country) Washington D. C. | | 12. CITIZEN OF WHAT COUNTRY? U.S. A. | |
| 13. FATHER'S NAME John Fitzhugh | | | | 14. MOTHER'S MAIDEN NAME Mary Burch | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 578 46 8808 | | 17. INFORMANT Rose M. Athey | | | |
| | | | | 6449 Old Landover Road Landover, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) Generalized Atherosclerosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 Days 2 yrs 2 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1964 , to Dec. 16, 1966 , that (I) (we) last saw the deceased alive on Dec 16 1966 , and that death occurred at 2:30 AM from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Samuel J. N. Sugar M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED Dec 16 1966 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Samuel J. N. Sugar | | | | 22d. ADDRESS 4637 Eastern Ave., Wash. 18, D.C. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/19/66 | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln | | 23d. LOCATION (City, town or county) (State) Colmar Manor P.G. Md. | |
| 24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE DEC 22 1966 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17729

CERTIFICATE OF DEATH

17726

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P G.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERSIDE</u> | | c. LENGTH OF STAY IN 1b <u>6 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENT WOOD</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial</u> | | d. STREET ADDRESS <u>4544 Rhode Island Ave</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>JAMES L FRANK VADEN</u> | | 4. DATE OF DEATH <u>DEC. 19 19 66</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-2-15</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | 9. AGE (In years last birthday) <u>51</u> yrs |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>FRANK VADEN</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillie Watson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES 1941-45</u> | | 16. SOCIAL SECURITY NO <u>1-41-45</u> | |
| 17. INFORMANT <u>Hospital Record - Leland Hospital</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> DUE TO (b) <u>ARTERIO SCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ACUTE PNEUMONITIS</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-12</u> , 19 <u>66</u> , to <u>12-19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>12-19</u> , 19 <u>66</u> , and that death occurred at <u>9:12 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>C. J. Houmann</u> | | 22b. DATE SIGNED <u>12-19-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u> | | 22d. ADDRESS <u>RIVERSIDE MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12-24-66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Memorial Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>John T. Rameco</u> | | 25a. REC'D BY REGISTRAR DATE <u>DEC 23 1966</u> | |
| ADDRESS <u>3015-12 ST NE</u> | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

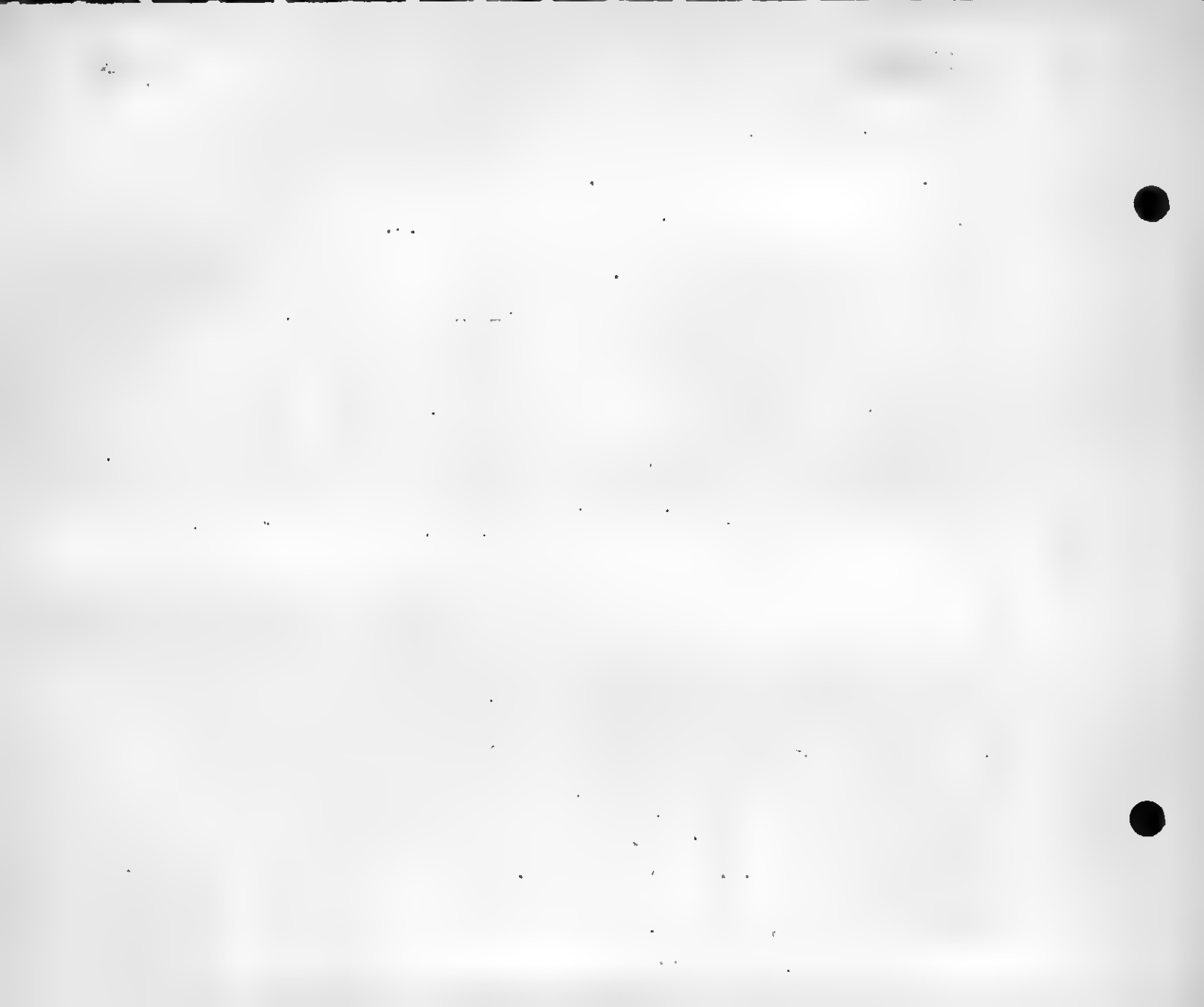
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

17730

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17727

| | | | | | | | |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. LENGTH OF STAY IN 1b <u>66 hrs.</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>College Park</u> <u>16.1</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George General Hospital</u> | | | | d. STREET ADDRESS <u>9808 17th. Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Elizabeth N. VanFleet</u> | | | | 4. DATE OF DEATH Month Day Year <u>12 6 19 66</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-16-1906</u> | | 9. AGE (in years last birthday) <u>60</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Arthur Norcross</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Annie Backus</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>021 03 2161</u> | | 17. INFORMANT <u>Robert Van Fleet</u> | | Address <u>Warwick Rhode Island.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>4040</u> DUE TO <u>Following immobilization of fracture of right femur</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in living room of home</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>5:30pm</u> <u>12-3-19 66</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>same as #2</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John Kehoe, M.D.</u> | | | | 22. DATE SIGNED <u>12-8-66</u> | | | |
| EXAMINER'S NAME (Type) <u>John Kehoe, M.D. Riverdale, Md.</u> | | | | Address (Street, city, town, or county) <u>Arlington National</u> | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Dec 9, 1966</u> | | 23c. NAME OF CEMETERY OR REPOSITORY <u>Arlington National</u> | | 23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u> | |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons Hyattsville, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>DEC 12 1966</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>O'Connell Judge</u> | | | |



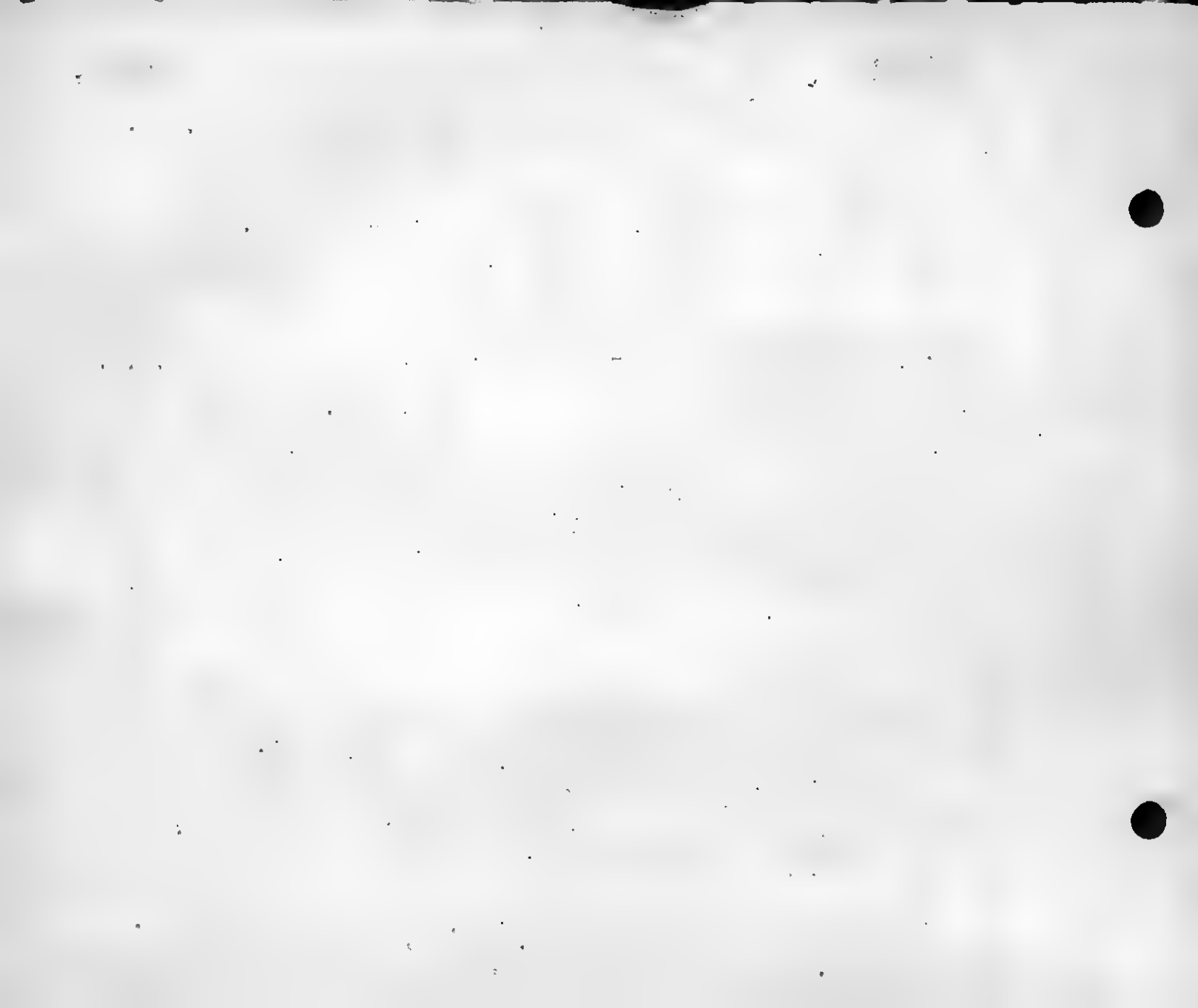
1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please provide carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
17731 CERTIFICATE OF DEATH 17728

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>PR. Geo.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. LENGTH OF STAY IN 1b <u>1 wk.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hyattsville Nursing Home</u> <u>6500 Riggs Rd. Hyattsville, Md.</u> | | d. STREET ADDRESS <u>4011 - 38th St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>V</u> Middle <u>Van Vacter</u> Last | | 4. DATE OF DEATH <u>December 13</u> 19 <u>66</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/20/1885</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 9b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | |
| 10a. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u> | | 10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 11. FATHER'S NAME <u>BGRON CARR</u> | | 12. MOTHER'S MAIDEN NAME <u>Willia E. Edwards</u> | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 14. SOCIAL SECURITY NO. <u>-</u> | |
| 15. INFORMANT <u>Estelle T. D'Andelet</u> | | Address <u>4011 38th St. Brentwood, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke type broncho pneumonia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic cardiovascular</u> DUE TO (c) <u>renal disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>44 hrs.</u> <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept.</u> 19 <u>66</u> to <u>13 Dec.</u> 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>12 Dec</u> 19 <u>66</u> , and that death occurred at <u>5:25</u> M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Thomas J. Mattingly</u> M.D. | | 22b. DATE SIGNED <u>13 Dec 66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Mattingly</u> | | 22d. ADDRESS <u>2200 R. I. Ave N.E. Wash. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>12/16/66</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Centralia Com.</u> | 23d. LOCATION (City, town or county) (State) <u>Centralia, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u> | | 25. REC'D BY REGISTRAR <u>DEC 16 1966</u> | |
| ADDRESS <u>Mt. Rainier Maryland</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

17732

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17729

| | | | | | | | |
|---|---------------------------|--|-----------------------------|--|--|---|--|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 9 hrs. 25 min. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | 16.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | d. STREET ADDRESS 7403 Keystone Lane | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Daniel S. Walker | | | | 4 DATE OF DEATH Month Day Year 12 31 1966 | | | |
| 5 SEX male | 6. COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-25-03 | | 9 AGE (In years last birthday) 63 yrs | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) PLUMBER | | 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | 11 BIRTHPLACE (State or foreign country) MARYLAND | | 12 CITIZEN OF WHAT COUNTRY? USA | |
| 13 FATHER'S NAME DANIEL G. WALKER | | | | 14 MOTHER'S MAIDEN NAME ELLEN EDELEN | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO 225-05-0907 | | 17. INFORMANT Laura Summers - 8524 MARLBOROUGH AVE | | Address DIST. 1875, MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X Cerebro Vascular thrombosis DUE TO (b) Cerebral arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH over 2 yrs | | | | | | | |
| PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John White M.D., Riverdale, Maryland | | | | 22. DATE SIGNED 1-2-66 | | | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify) | | 23b. DATE THEREOF 1/4/1967 | | 23c. NAME OF CEMETERY OR CREMATORY Addison Chapel Cem. | | 23d. LOCATION (City or town) (County) (State) Seat Pleasant, Md. | |
| 24 FUNERAL DIRECTOR W.W. CHAMBERS Co. WASHINGTON, DC. | | | | 25a. REC'D BY REGISTRAR DATE JAN 6 1967 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17730

| | | | | | |
|--|-----------------------|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | | d. STREET ADDRESS 4713 Homer Avenue | | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Nella Virginia Walker | | | 4 DATE OF DEATH Month 12 Day 20 Year 19 66 | | |
| 5 SEX Female | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 8 Oct. 1893 | | 9 AGE (In years last birthday) 73 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Domestic | | 11 BIRTHPLACE (State or foreign country) West Va. | |
| 13 FATHER'S NAME William Powell | | | 14. MOTHER'S MAIDEN NAME Unknown | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO 159-22-0081 | | 17 INFORMANT Address John G. Walker (Son) Same as # 2. | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 1B) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) | |
| | | | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | | 22. DATE SIGNED 12-21-66 | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | | Address (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE THEREOF Dec. 21st 66 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | |
| | | | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | |
| 24 FUNERAL DIRECTOR Simmons Brothers | | | 25a. REC'D BY REG. STRAR DEC 23 1966 | | 25b. REGISTRAR'S SIGNATURE |
| 1661-Gd. Hope Rd. SE, Wash., D.C. | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1 (M)

17734

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17731

| | | | |
|--|------------------------|--|--------------------------------|
| 1. PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b DOA | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital | | d STREET ADDRESS 7657 Kilmer Street | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Mabel Josephine Walter | | 4. DATE OF DEATH Month Day Year Dec 31 19 66 | |
| 5. SEX female | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 3, 1925 |
| 9. AGE (In years last birthday) yrs 71 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | |
| 11. BIRTHPLACE (State or foreign country) New York | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Edwin Costello | | 14. MOTHER'S MAIDEN NAME Adele Maurice | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Joseph Walter | | Address Same as # 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH minutes 20 years | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D. | | 22. DATE SIGNED 1-2-67 | |
| EXAMINER'S NAME (Type) John Kehoe, M.D. | | 22. DATE SIGNED 1-2-67 | |
| 23a. BURIAL, CREMATION, REMOVAL. Specify Burial | | 23b. DATE THEREOF 1-3-1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 23d. LOCATION (City or town) (County) (State) Suitland Prince Geo Md | |
| 24. FUNERAL DIRECTOR Robert A. Mattingly | | 25. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

17735

CERTIFICATE OF DEATH

17732

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

| | | | | | | | |
|---|--------------------------|--|------------------------------|--|---------------------------------------|--|--|
| 1 PLACE OF DEATH a COUNTY Prince Georges MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | | | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Forestville | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ritchie | | e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Regent Nursing & Rehabilitation Center | | | | d STREET ADDRESS 516 Ritchie Road | | | |
| 3 NAME OF DECEASED (Type or print) CHARLES C. Watson | | | | 4. DATE OF DEATH Month 12 Day 17 Year 1966 | | | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 10-3-1884 | | 9 AGE (In years last birthday) yrs 82 | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b KIND OF BUSINESS OR INDUSTRY | | 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Melvin R. Watson | | | | 14. MOTHER'S MAIDEN NAME Agnes E. Moran | | | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16 SOCIAL SECURITY NO. | | 17. INFORMANT Effie M. Watson 516 Ritchie Rd Ritchie Md | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO Generalized Arteriosclerosis (b) DUE TO (c) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3 mos. Many YEARS | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 10-14, 1966 to 12-17, 1966, that (I) (we) last saw the deceased alive on 12-16, 1966, and that death occurred at 12:30 PM, from causes and on the date stated above. | | | | | | | |
| 22a SIGNATURE W B Sheer | | | | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b DATE SIGNED 12-17-66 | |
| 22c PHYSICIAN'S NAME (Type) WALTER B. SHEER | | | | 22d ADDRESS 6400 MARLBORO PIKE S.E. WASH. DC | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12-20-1966 | | 23c NAME OF CEMETERY OR CREMATORY Epiphany Cemetery | | 23d LOCATION (City or town) (County) (State) Forestville Maryland | |
| 24 FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd | | | | ADDRESS Suitland Maryland | | 25a REC'D BY REGISTRAR DATE DEC 21 1966 | |
| | | | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |

FOR STATE HEALTH DEPT.

12
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if only delays necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill out Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal.

VR A15ME
6M 1/66

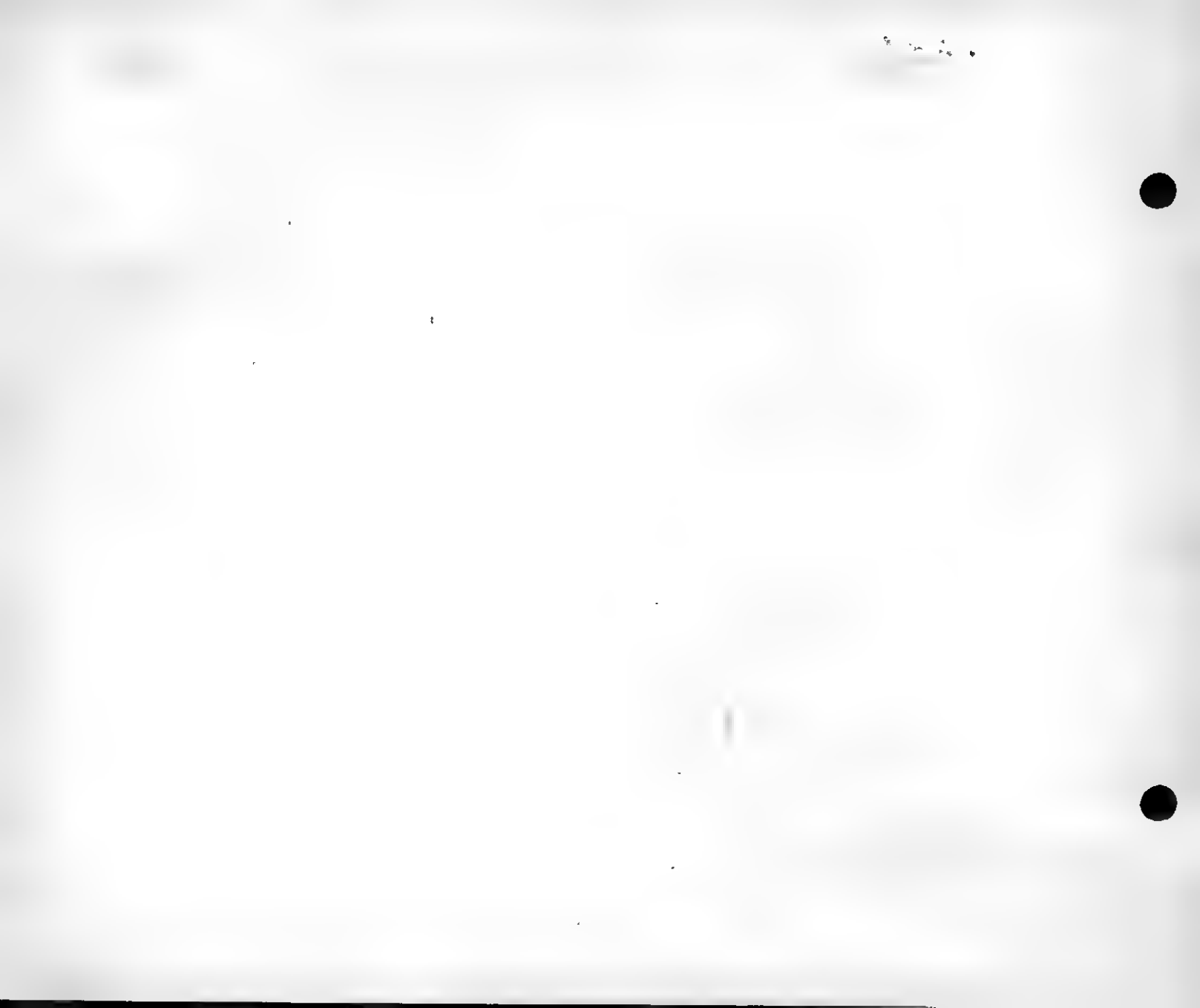
Items 18-21 Fill in 3-27-MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #3 Form #8387 1/3/67 pc

17736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17733

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN Tb DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Tuxedo d. STREET ADDRESS 2310 57th Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Wilton Middle Ellsworth Last Watts | | 4. DATE OF DEATH Month 12 Day 9 Year 1966 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2 Aug., 1913 |
| 9. AGE (in years last birthday) 53 yrs | | 10. IF UNDER 1 YEAR Months 9 Days 19 Hours 66 Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist | | 10b. KIND OF BUSINESS OR INDUSTRY Own business | |
| 11. BIRTHPLACE (State or foreign country) Pro Geo County, Md. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Wilton Ellsworth Watts Sr | | 14. MOTHER'S MAIDEN NAME Ethel B Pryor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 577 18 0068 | |
| 17. INFORMANT Annie Helen Watts | | Address Tuxedo, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY 1880 IMMEDIATE CAUSE (a) Combined intoxication - alcohol and DUE TO (b) barbiturate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Took barbiturates while under the influence of alcohol | |
| 20c. TIME OF DEATH Month, Day, Year pm Hour 12-9 Day 19 Year 66 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home farm, factory, street, office bldg, etc.) Home | 20f. (City or town) (County) (State) Tuxedo Pr. Geo. Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | 22. DATE SIGNED 12-11-66 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF Dec 13, 1966 | |
| 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | |
| 25a. REC'D BY REGISTRAR DEC 15 1966 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 17737 | | | | | | | | | | | | 17734 | | | |
|---|--|-------------------------------|--|---|--|---|--|--|---|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville c. LENGTH OF STAY IN 1b MA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Home | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hackensack d. STREET ADDRESS 153 Fairmount Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Lillian Middle Anna Last Weisbecker | | | | | | 4. DATE OF DEATH Month December Day 25 Year 1966 | | | | | | | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH April 7, 1883 | | 9. AGE (In years last birthday) 83 yrs. | | IF UNDER 1 YEAR Months 10 Days 17 Hours 15 Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Cincinnati, Ohio | | | 12. CITIZEN OF WHAT COUNTRY? United States | | | | | | |
| 13. FATHER'S NAME Benjamin Bolmer | | | | | | 14. MOTHER'S MAIDEN NAME Anna Alberts | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Sacred Heart Home, Hyattsville, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 446X DUE TO Chronic Cerebrovascular Insufficiency (b) DUE TO Sclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/10/66 to 12/23/66 , 19 66 , that (I) (we) last saw the deceased alive on 12/23 , 19 66 , and that death occurred at 11:15 PM, from the causes and on the date stated above. | | | | | | | | | | | | | | | |
| 22a. SIGNATURE Robert C. Haile | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 12/26/66 | | | |
| 22c. PHYSICIAN'S NAME (Type) ROBERT C HAILE | | | | | | 22d. ADDRESS 35 NEW YORK AVE N.W. WASH, D.C. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 23b. DATE THEREOF 12-29-66 | | 23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CEMETERY | | | | 23d. LOCATION (City, town or county) (State) BLADENSBURG RD WASH, D.C. | | | | | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co | | | | | | ADDRESS 3072 M-14120. WASH, D.C. | | 25a. REC'D BY REGISTRAR 11-10-66 | | 25b. REGISTRAR'S SIGNATURE J. J. J. J. | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17738

CERTIFICATE OF DEATH

17735

| | | | |
|---|--------------------------|--|---------------------------------|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's | |
| b CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Cheverly | | c LENGTH OF STAY IN 1b D. O. A. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's Hospital | | d. STREET ADDRESS 9332 4th street | |
| 3 NAME OF DECEASED (Type or print) First William V. Wert Middle Last | | 4. DATE OF DEATH Month December Day 6, Year 19 66 | |
| 5 SEX Male | 6 COLOR OR RACE white | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH July 8, 1898 |
| 9. AGE (In years last birthday) 68 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired optical shop | | 10b KIND OF BUSINESS OR INDUSTRY Navy Yard | |
| 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12 CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME William Wert | | 14 MOTHER'S MAIDEN NAME Aura Maury | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO 207 07 2197 | |
| 17 INFORMANT Florence T. Wert Same as #2 (wife) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 mo</u> (c) | | INTERVAL BETWEEN ONSET AND DEATH 9 mo | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21 I certify that (I) (this hospital) attended the deceased from <u>May 19 64</u> , 19 <u>64</u> , to <u>Dec 6</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>Dec 2</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>L W Malin</u> M D | | 22b DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u> | | 22d ADDRESS <u>Kennedys, 2222</u> | |
| 23a BURIAL, CREMATION, REMOVAL Cremation | | 23b DATE THEREOF 12/10/66 | |
| 23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln crematory | | 23d LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md. | |
| 24 FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland | | 25a REC'D BY REGISTRAR DATE DEC 8 1966 | |
| 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17736

| | | | |
|---|--|---|---|
| 1 PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b DOA | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | d. STREET ADDRESS Rt. 1, Box 51 (Brady's Lane) | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Angela Rose Wesley | | 4. DATE OF DEATH Month 12-11 Day 19 Year 66 | |
| 5 SEX F | 6 COLOR OR RACE W | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 24 Sept., 1966 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None | | 10b. KIND OF BUSINESS OR INDUSTRY None | 9 AGE (In years last birthday) yrs 2 17 |
| 11 BIRTHPLACE (State or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13 FATHER'S NAME Michael J. Wesley, Sr. | | 14 MOTHER'S MAIDEN NAME Patricia G. Sardo | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or Unknown) No | | 16 SOCIAL SECURITY NO. ----- | |
| 17 INFORMANT Michael J. Wesley, Jr. | | Address Sameas #2 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral pneumonitis DUE TO (SDII) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | 22. DATE SIGNED 12-11-66 | |
| EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, or other disposal | | 23b. DATE THEREOF 12/15/66 | |
| 23c. NAME OF CEMETERY OR CREMATOR Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington D.C. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons 4739 Balt. Ave. Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DATE DEC 19 1966 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

17740

17737

| | | | |
|--|-------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>670 8th St.</u> | | d. STREET ADDRESS <u>670 8th Street</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Matilda Ann Wesley</u> | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 14 1877</u> |
| 9. AGE (In years last birthday) <u>89</u> | | 10. AGE (In years last birthday) <u>89</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Washington Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Carter</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>101-10-1010</u> | |
| 17. INFORMANT <u>Earl Wesley (son)</u> | | Address <u>816 Maple Ave Laurel, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A-S-C-V-D Disease</u> DUE TO (b) <u>Gen'l A-S</u> DUE TO (c) <u>Respirator Myelitis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>11 yrs</u> INTERVAL BETWEEN ONSET AND DEATH (b) <u>21 yrs</u> (c) <u>20 yrs</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2/15/66</u> to <u>12/7/66</u> , that (I) (we) last saw the deceased alive on <u>12/7/66</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>J M Warren</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>12/12/66</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Queens Chapel Cem.</u> | | 23d. LOCATION (City, town or county) (State) <u>Muir Kirk, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR <u>DEC 15 1966</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 17741 | | | | | CERTIFICATE OF DEATH | | | | | Reg. Dist. No. 17738 | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u> | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> <u>✓</u> b. COUNTY <u>✓</u> | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lanham, Md.</u> | | | | | c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47</u> | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Magnolia Gardens Nursing Home</u> | | | | | d. STREET ADDRESS <u>1225 13th St NW</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Flora</u> Middle <u>H.</u> Last <u>WETZEL</u> | | | | | 4. DATE OF DEATH Month <u>Dec.</u> Day <u>10</u> Year <u>1966</u> | | | | | | | | | | | | | | | | | | | |
| 5. SEX <u>Female</u> | | | | | 6. COLOR OR RACE <u>White</u> | | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | | | | |
| 8. DATE OF BIRTH <u>March 13, 1879</u> | | | | | 9. AGE (In years last birthday) <u>87</u> yrs | | | | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>27</u> Hours <u></u> Min <u></u> | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | | 11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u> | | | | | | | | | | | | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | 13. FATHER'S NAME <u>Daniel Wilbur Wetzel</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Flora H. Hessick</u> | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | | | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | | | | 17. INFORMANT <u>GEO. L. MASON (Bro.)</u> Address <u>Landover, Md.</u> | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic cancer of lung breast</u> (c) <u>cancer of breast</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>3 months</u> <u>?</u> | | | | | | | | | | | | | | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u> | | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | | | |
| 20f. (City or town) | | | | | (County) | | | | | (State) | | | | | | | | | | | | | | |
| 21. I certify that I attended the deceased from <u>June 1966</u> , 19 <u>66</u> to <u>12/10/66</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>12/9/66</u> , 19 <u>66</u> , and that death occurred at <u>10:35 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>12-10-66</u> DATE SIGNED <u>12/10/66</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Leon Levitsky</u> M.D. <u>3408-R.I. Ave., Mt. Rainier, MD.</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>LEON LEVITSKY, MD.</u> <u>3408-RHODE ISLAND AVE., MT. RAINIER, MD.</u> | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | | | | 22b. DATE THEREOF <u>DEC. 13/66</u> | | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON NATIONAL CEM.</u> | | | | | | | | | | | | | | |
| 22d. LOCATION (City, town, or county) <u>SUITLAND, MARYLAND</u> | | | | | 22e. (State) <u>MARYLAND</u> | | | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>M. W. HYSOY CO., INC.</u> <u>James M. Hysong</u> | | | | | | | | | | | | | | | ADDRESS <u>1300-N ST. N.W.</u> <u>WASH. D.C.</u> | | | | | 24a. REC'D BY REGISTRAR DATE <u>DEC 13 1966</u> | | | | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | | | | | | |

FOR STATE
HEALTH DEPT.

17742

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17739

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|-----------------------|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission on) a. STATE Md. b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Landover | | c. LENGTH OF STAY IN 1b Landover | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Home-Same as #2 | | d. STREET ADDRESS 2607 Prince George Ave., | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Drucie Marie Thetstone | | 4. DATE OF DEATH Month Day Year 12-17 19 66 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED | 8. DATE OF BIRTH 2 Jan. 1890 |
| 9. AGE (In years last birthday) 76 yrs | | 10. FUNDING YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 12. KIND OF BUSINESS OR INDUSTRY | |
| 13. BIRTHPLACE (State or foreign country) Indiana | | 14. CITIZEN OF WHAT COUNTRY? U.S. | |
| 15. FATHER'S NAME Pierre Mc Mahon | | 16. MOTHER'S MAIDEN NAME Laura Walden | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) If yes give war or dates of service) no | | 18. SOCIAL SECURITY NO. unknown | |
| 19. INFORMANT Richard Walden | | 20. ADDRESS 248 West Vine St. Charleston Illinois | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic heart disease DUE TO (c) | | 22. INTERVAL BETWEEN ONSET AND DEATH Minutes Un'known | |
| 23. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 25a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 25b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 26a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 26b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 26c. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | | 26d. (City or town) (County) (State) | |
| 27. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| 28. ACTUAL SIGNATURE John Kehoe M.D. EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | 29. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 30. DATE SIGNED 12-18-66 | | 31. 22. DATE SIGNED | |
| 32a. BURIAL, CREMATION, REMOVAL <input type="checkbox"/> 32b. DATE THEREOF Dec 23, 1966 | | 32c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park | |
| 32d. LOCATION (City or Town) (County) (State) Frostburg Maryland | | 32e. REC'D BY REGISTRAR DEC 27 1966 | |
| 32f. REGISTRAR'S SIGNATURE Charles Judge | | 32g. REGISTRAR'S SIGNATURE | |
| 32h. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md. | | 32i. FUNERAL DIRECTOR | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in the space provided for the signature of the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

17743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17740

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a COUNTY Prince George's MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Prince George's | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | c LENGTH OF STAY IN Pl | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6700 Belcrest Road, Apt. 508 | | d STREET ADDRESS 6700 Belcrest Road, Apt. 508 | |
| 3 NAME OF DECEASED (Type or print) Percy Copeland White | | 4 DATE OF DEATH 12 28 19 66 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 8 Oct. 1912 |
| 9 AGE (In years last birthday) 54 yrs | | 10 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIRM EXECUTIVE | |
| 11 BIRTHPLACE (State or foreign country) NEW YORK | | 12 CITIZEN OF WHAT COUNTRY? U.S. | |
| 13 FATHER'S NAME UNKNOWN Harry Weitz | | 14 MOTHER'S MAIDEN NAME FANNIE COPELAND | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16 SOCIAL SECURITY NO UNKNOWN | |
| 17 INFORMANT FRANCES B. WHITE | | Address RHODESDALE, MD | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) | | | INTERVAL BETWEEN ONSET AND DEATH minutes unknown |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D. Riverdale, Md. | | 22. DATE SIGNED 12-29-66 | |
| 23a DATE OF BURIAL OR CREMATION 12-30-1966 | | 23b DATE THEREOF 12-30-1966 | |
| 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or town) (County) (State) NEW YORK CITY N.Y. | |
| 24 FUNERAL DIRECTOR W.W. Chambers Co Riverdale, Md. | | 25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE | |
| DATE JAN 3 1967 | | | |

17744

CERTIFICATE OF DEATH

17741

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH a COUNTY Prince Georges b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c LENGTH OF STAY IN lb 12 days | | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY Prince Georges c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges General Hospital | | d STREET ADDRESS 3557 55th Ave. Apt. 11 | |
| 3 NAME OF DECEASED (Type or print) First Middle Last Baby Boy Williams | | 4 DATE OF DEATH Month Day Year Dec 26 1966 | |
| 5 SEX Male | 6 COLOR OR RACE White | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH 14 Dec 1966 |
| 9 AGE (In years last birthday) yrs 12 | | 10 IF UNDER 1 YEAR Months Days Hours Min. 12 | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | 10b KIND OF BUSINESS OR INDUSTRY - | |
| 11 BIRTHPLACE (County & State, or foreign country) Maryland | | 12 CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13 FATHER'S NAME Dwight C. Williams Jr. | | 14 MOTHER'S MAIDEN NAME Mary Haronitore | |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16 SOCIAL SECURITY NO. - | |
| 17 INFORMANT Mr. Dwight C. Williams Jr. (above address) | | Address | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 1776X IMMEDIATE CAUSE (a) Prematurity DUE TO (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 12 days | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c TIME OF INJURY Month, Day, Year hour a.m. p.m. 19 | | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) |
| 20f (City or town) | | (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 3:30 AM , from causes and on the date stated above. | | | |
| 22a SIGNATURE <i>[Signature]</i> | | 22b. DATE SIGNED | |
| 22c PHYSICIAN'S NAME (Type) | | 22d ADDRESS | |
| 23a BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b DATE THEREOF 12/28/66 | |
| 23c NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem. | | 23d LOCATION (City or Town) (County) (State) Arlington, Va. | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | ADDRESS Mt. Rainier Maryland | |
| 25a REC'D BY REGISTRAR DEC 29 1966 | | 25b REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISM (5)
5M 1/65

17745

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17742

| | | | | | | | |
|--|-----------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton | | c. LENGTH OF STAY IN 1b DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clinton | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Southern Md. Medical Center | | | | d. STREET ADDRESS 7500 Grace Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last David Edward Wilson | | | | 4. DATE OF DEATH Month Day Year 12 8 1966 | | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 27 June, 1938 | | 9. AGE (In years last birthday) 28 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAM FITTER | | 10b. KIND OF BUSINESS OR INDUSTRY YORK CORP | | 11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C | | 12. CITIZEN OF WHAT COUNTRY U.S | |
| 13. FATHER'S NAME JOSEPH D. WILSON | | | | 14. MOTHER'S MAIDEN NAME JEANETTE PERCIVAL | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO. 577-52-8474 | | 17. INFORMANT MRS BARBARA WILSON Address SAME AS H | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Laceration of brain 5x3.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Multiple skull fractures DUE TO (c) Trauma-auto accident Minutes | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of car which ran off road and hit pole | | | | | |
| 20c. TIME OF INJURY Month, Day, Year 10:15 a.m. 12 8 1966 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Old Branch Ave. | | 20f. (City or town) (County) (State) P.G. Md. | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> John Kehoe, M.D., Riverdale | | | | 22. DATE SIGNED 12-9-66 | |
| EXAMINER'S NAME (Type) | | Address (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 13 Dec 1966 | | 23c. NAME OF CEMETERY OR CREMATORY Washington National | | 23d. LOCATION (City, town or county) (State) Suitland, MARYLAND | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md | | | | 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE DATE DEC 15 1966 | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

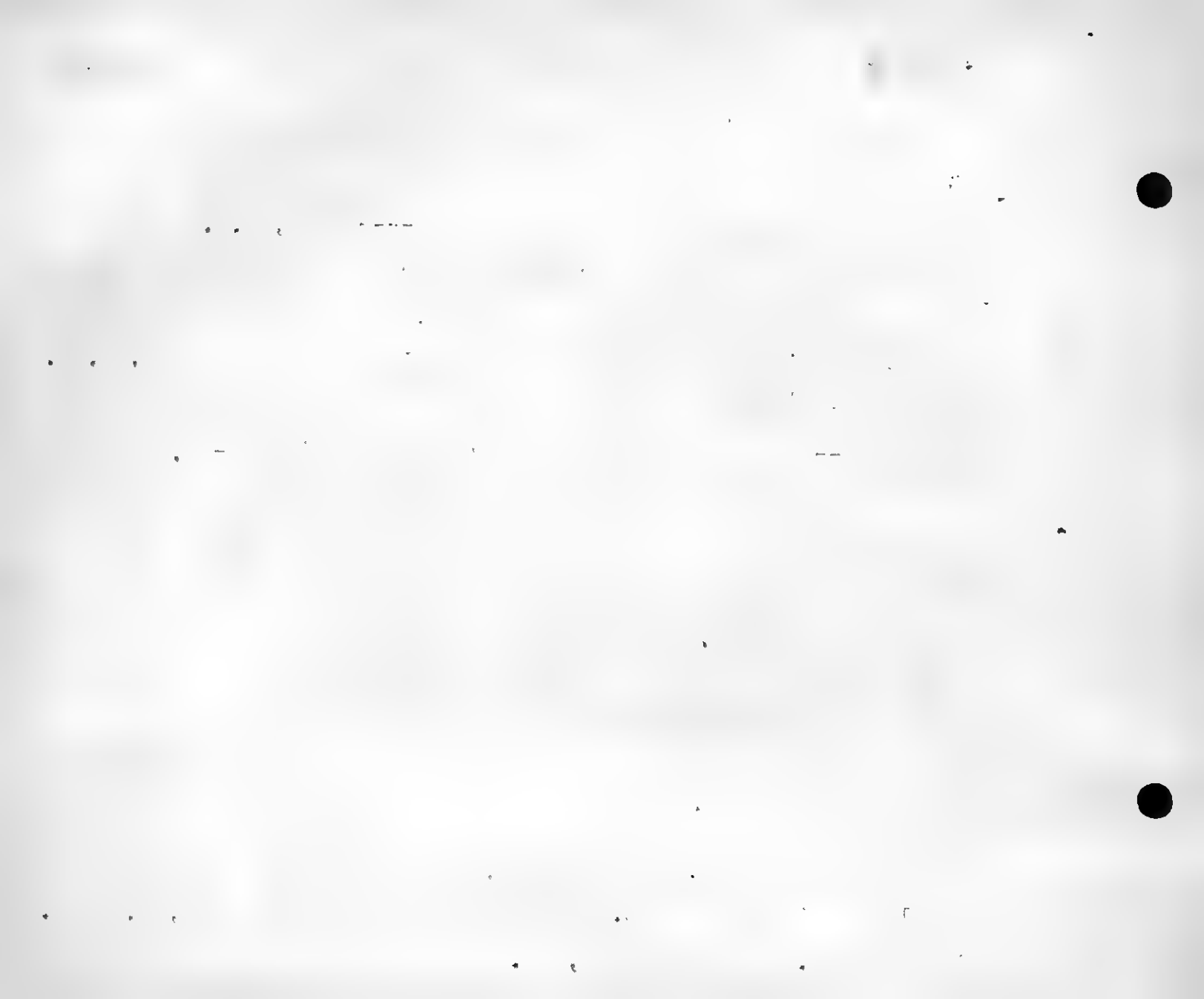
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17746

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

17743

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (RURAL) Upper Marlboro | |
| c. LENGTH OF STAY IN 1b DOA | | d. STREET ADDRESS Ritchie 1005 Ritchie Road, S.E. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last John Everett Windsor | | 4. DATE OF DEATH Month Day Year 12 30 19 66 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 16 Dec. 1894 |
| 9. AGE (In years last birthday) 72 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tobacco Farming | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME John Albert Windsor | | 14. MOTHER'S MAIDEN NAME Mary Violet Garner | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown -- | | 16. SOCIAL SECURITY NO -- | |
| 17. INFORMANT Clara Estelle Windsor-#2. | | Address Same as Item | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Arteriosclerotic heart disease (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: _____ | | INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____ | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John Kehoe, I.D. M.D. | | 22. DATE SIGNED 12-30-66 | |
| EXAMINER'S NAME (Type) John Kehoe, I.D. Riverdale, Md. | | Address (Street, city, town, or county) _____ | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | 23b. DATE THEREOF 1/3/67 | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | 23d. LOCATION (City or town) (County) (State) Bladensburg, Pr. Geo. Md. |
| 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. | | 25a. REC'D BY REG. STRAR DATE JAN 6 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

17747

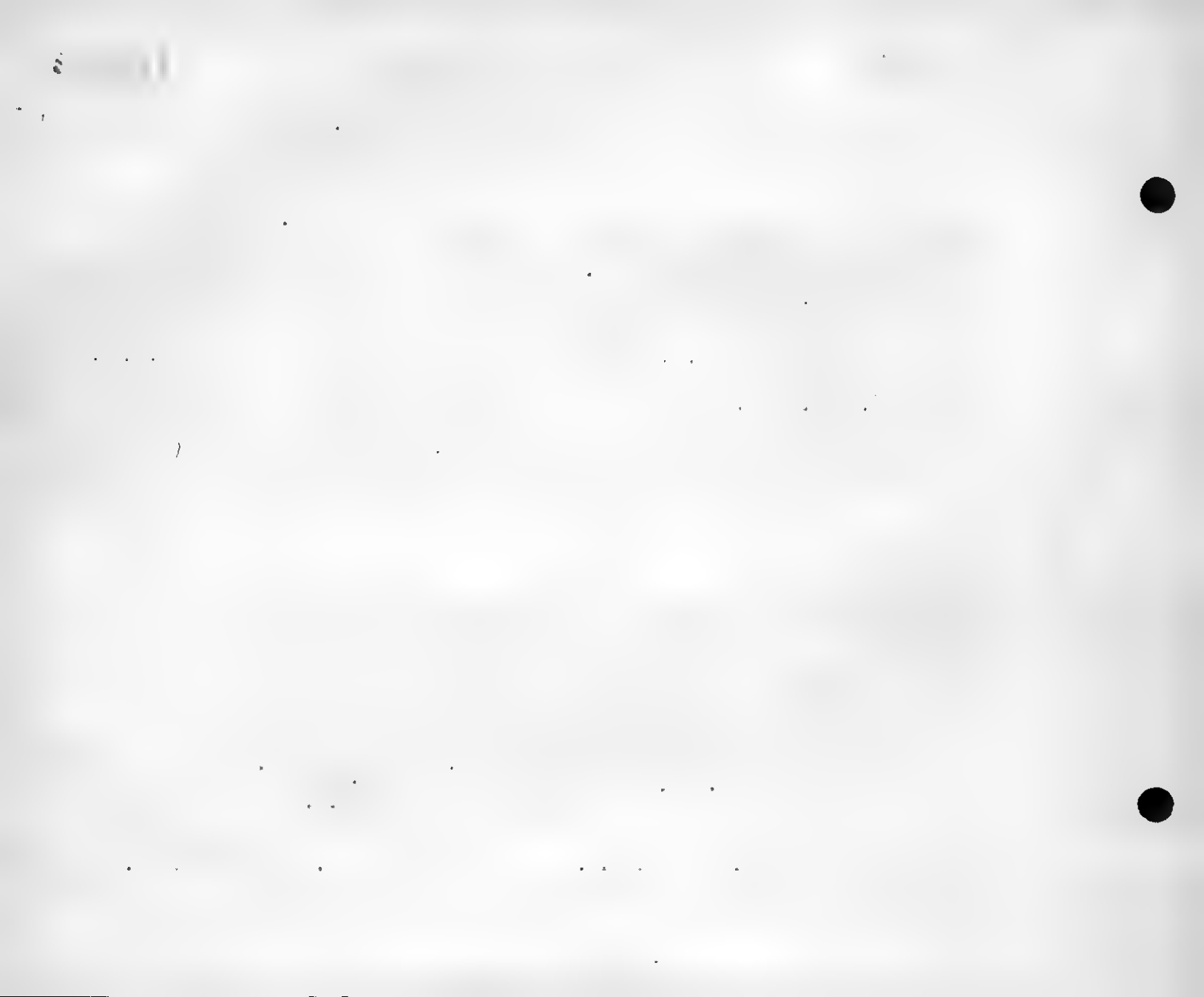
CERTIFICATE OF DEATH

17744

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 1 day | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Seabrook |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 9505 Sheridan St. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Joseph Middle C. Last Wolfe | | 4. DATE OF DEATH Month December Day 30 Year 1966 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/13/26 |
| 9. AGE (In years last birthday) 40 yrs | | 10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photographer | | 10b. KIND OF BUSINESS OR INDUSTRY U.S. Government | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania |
| 12. CITIZENSHIP OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Joseph C. Wolfe Sr. | |
| 14. MOTHER'S MAIDEN NAME Stella Fagan | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) yes WW 11 | |
| 16. SOCIAL SECURITY NO. 579 26 3232 | | 17. INFORMANT Mary E. Wolfe Same as #2 (wife) Address | |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY 151X IMMEDIATE CAUSE (a) Severe Malnutrition & emaciation DUE TO (b) Carcinoma of stomach with complete DUE TO (c) obstruction | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/> | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from Sept. , 1963, to Dec. 30 , 1966, that (I) (we) lost saw the deceased alive on Dec. 30 , 1966, and that death occurred at 4:10 M, from causes and on the date stated above. | |
| 22a. SIGNATURE Frederick E. Musser, M.D. | | 22b. DATE SIGNED 12/30/66 | |
| 22c. PHYSICIAN'S NAME (Type) Frederick E. Musser, M.D. | | 22d. ADDRESS 4410 74th Ave., Bellemead, Md. | |
| 23a. BURIAL, CREMATION, BURNED (Specify) | | 23b. DATE THEREOF 1/3/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington Arlington Va. | |
| 24. FUNERAL DIRECTOR F. Gaschis Son - Hyattsville, Md | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE Charles J. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

17748

CERTIFICATE OF DEATH

17745

Items 3, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

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|--|--|---|--|--|--|--|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE'S | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND | | b. COUNTY PRINCE GEORGE'S COUNTY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) COLLEGE PARK | | d. STREET ADDRESS 3619 MARLBROUGH WAY | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) First GEORGE | | Middle W. | | Last WOOD | | 4. DATE OF DEATH Month 12 | | Day 26 | | Year 1966 | | 5. SEX M | | 6. COLOR OR RACE W | | | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH 11-8-73 | | 9. AGE (In years last birthday) 93 | | 10. UNDER 1 YEAR Months 9 | | 11. UNDER 24 HRS. Days 3 | | 12. HOURS 19 | | 13. MIN. 66 | | 14. WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | | 11. BIRTHPLACE (County & State, or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME James Wood | | 14. MOTHER'S MAIDEN NAME Malinda Schnoover | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no | | 16. SOCIAL SECURITY NO. 219 54 7241 | | | | | |
| 17. INFORMANT Pennfeather | | Address Mrs. Tennessee Feather | | Daughter Same as #2 | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 33-X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 2-3 med | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 20. WAS DEATH CAUSED BY (b) (c) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 1962 , to 12-26, 1966 , that (I) (we) last saw the deceased alive on 12-26-66 19, and that death occurred at 10:50 AM , from the causes and on the date stated above. | | 22a. SIGNATURE Donald C. Edgren | | 22b. DATE SIGNED 12-26-66 | | | |
| 22c. PHYSICIAN'S NAME (Type) Donald C. Edgren | | 22d. ADDRESS Hyattsville Md. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12/29/66 | | 23c. NAME OF CEMETERY OR CREMATORY Riverside | | 23d. LOCATION (City, town or county) (State) Towanda Pa | | 24. FUNERAL DIRECTOR F. Gasch's Sons | | 25. ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR DEC 29 1966 | | 25b. REGISTRAR'S SIGNATURE J. M. Jones | |

17749

CERTIFICATE OF DEATH

17746

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|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Prince George's | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 57 days | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maryland Park |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | d. STREET ADDRESS 6500 D St. | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Grace Middle J. Last Wood | | 4. DATE OF DEATH Month December Day 29 Year 66 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/3/03 |
| 9. AGE (In years last birthday) 63 yrs. | | 10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) New York |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Esengbrietsen | |
| 14. MOTHER'S MAIDEN NAME Joanna Pauline | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO | | 17. INFORMANT Charles E. Wood Address Same as #2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Swine, Pulmonary Edema DUE TO Massive Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Pneumonia (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/16 , 1966, to 12-29 , 1966, that (I) (we) last saw the deceased alive on 12-29 , 1966, and that death occurred at 2:00 P.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE SIGNED 12-30-66 | |
| 22c. PHYSICIAN'S NAME (Type) DR DAVID ANDERS | | 22d. ADDRESS 3308 Dodge Park Rd Landover Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 1-3-1967 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 23d. LOCATION (City or Town) (County) (State) Suitland, prince George |
| 24. FUNERAL DIRECTOR William G 131-11th St S.E. D.C. | | 25a. REC'D BY REGISTRAR DATE JAN 3 1967 | 25b. REGISTRAR'S SIGNATURE [Signature] |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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17750

CERTIFICATE OF DEATH

17747

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| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LANHAM, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Heights, Md.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAGNOLIA GARDENS NURSING HOME</u> | | d. STREET ADDRESS <u>6801 PINEWAY</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>C.</u> Last <u>WOODWARD</u> | | 4. DATE OF DEATH Month <u>DEC.</u> Day <u>15</u> Year <u>1966</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 15, 1887</u> |
| 9. AGE (in years last birthday) <u>79</u> yrs | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>16</u> Min <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Albert W. Chappel</u> | | 14. MOTHER'S MAIDEN NAME <u>Cora Bedell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>219 349961</u> | |
| 17. INFORMANT <u>Thompson E Woodward</u> | | Address <u>College Heights, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) _____ DUE TO (c) <u>Cerebral arteriosclerosis</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 10, 1966</u> to <u>Dec. 15, 1966</u> that (I) (we) last saw the deceased alive on <u>Dec. 11, 1966</u> , and that death occurred at <u>1:55 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Don B. Cameron</u> | | 22b. DATE SIGNED <u>12-15-66</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Don B. Cameron</u> <u>3503 PERRY ST.</u> | | 22d. ADDRESS <u>MT. RAINIER, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>Dec 19, 1966</u> | 23c. NAME OF CEMETERY OR REPOSITORY <u>St John's Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Bethesda Pro Geo Md</u> |
| 24. FUNERAL DIRECTOR <u>F. Seachi Sons Hyattsville Md.</u> | | 25. REC'D BY REGISTRAR DATE <u>DEC 19 1966</u> | 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #6 Film #G-388 5/18/67 pc

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 17751 | | 17748 | |
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY P.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly | | c. LENGTH OF STAY IN 1b 3 hours | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro | | d. STREET ADDRESS Box 1052 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE GENERAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) PRINCE GEORGE GENERAL | | 4. DATE OF DEATH Month 12 Day 31 Year 1966 | |
| 5. SEX Female | | 6. COLOR OR RACE White | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 6-6-09 | |
| 9. AGE (In years last birthday) 57 yrs. | | 10. IF UNDER 1 YEAR Months 12 Days 31 Hours 00 Min. 00 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINCIPAL PUBLIC SCHOOL, MD. STATE | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME WILLIAM D. QUANDER | | 14. MOTHER'S MAIDEN NAME MARY E. GREENFIELD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-03-2109 | |
| 17. INFORMANT BENJ. M. YOUNG | | Address SEE 2 B | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) CVA DUE TO (b) Hypertensive crisis DUE TO (c) Essential hypertension | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 12/20 , 19 66 , to 12/31 , 19 66 that (I) (we) last saw the deceased alive on 12/31 , 19 66 , and that death occurred at 2:30 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE [Signature] | | 22b. DATE SIGNED 12/31/66 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1/7/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY | | 23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C. | |
| 24. FUNERAL DIRECTOR Robert E. Smith | | 25a. REC'D BY REGISTRAR 1820 9TH, N.W. | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | DATE JAN 5 1967 | |

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CERTIFICATE OF DEATH

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|--|-----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel, Maryland | |
| c. LENGTH OF STAY IN 1b 66 years | | d. STREET ADDRESS 318 Second Street | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 318 Second Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) AGNES VIRGINIA ZALONIS | | 4. DATE OF DEATH December 8, 1966 | |
| 5. SEX Female | 6. COLOR OR RACE Caucasian | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH December 8, 1895 |
| 9. AGE (In years last birthday) 71 yrs. | | 10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 11a. USUAL OCCUPATION (Give kind of work done) Clerk-Stenogr, US Govt | | 11b. KIND OF BUSINESS OR INDUSTRY US Govt; Dep Agric | |
| 11. BIRTHPLACE (County & State, or foreign country) Alexandria, Virginia | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Henry Collins | | 14. MOTHER'S MAIDEN NAME John Anna White | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or not known) No | | 16. SOCIAL SECURITY NO. 213-56-1498 | |
| 17. INFORMANT Husband: John Anthony Zalonis | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2865 IMMEDIATE CAUSE (a) Hypo-albuminemia, hypo-kalemia, anemia DUE TO (b) cirrhosis of liver DUE TO (c) subnutrition, adult-type (dietary selectivity) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (July to Oct 66) Cholelithiasis; Entero-colitis due to Staph. aureus | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH 6 mon. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 27 Sept , 1966, to 8 Dec , 1966, that (I) (we) last saw the deceased alive on 7 Dec , 1966, and that death occurred at 6 A M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE Richard Compton M.D. | | 22b. DATE SIGNED 8 December 1966 | |
| 22c. PHYSICIAN'S NAME (Type) J. Richard Compton, M.D. | | 22d. ADDRESS 612 Main Street, Laurel, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 12-12-66 | |
| 23c. NAME OF CEMETERY OR CREMATORY St Marys Cem. | | 23d. LOCATION (City or Town) (County) (State) Laurel Md. | |
| 24. FUNERAL DIRECTOR De Witt Canalehan, Laurel, Md. | | 25a. REC'D BY REGISTRAR DEC 21 1966 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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